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LEGISLATIVE ASSEMBLY

1981


THE INSURANCE INDUSTRY
FIFTH REPORT ON
ACCIDENT AND SICKNESS INSURANCE

THE SELECT COMMITTEE
ON
COMPANY LAW

Tabled in the Legislative Assembly
by

JAMES R. BREITHAUP, Q.C., M.P.P.
CHAIRMAN

First Session, 32nd Parliament, 29 ELIZABETH II



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The Honourable John M. Turner, M.P.P.,
Speaker of the Legislative Assembly of
the Province of Ontario.

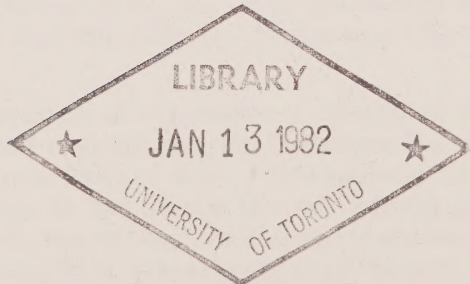
Sir:

The Select Committee on Company Law has now the honour to submit its
Fifth Report on Accident and Sickness Insurance.

A handwritten signature in dark ink, appearing to read 'J. Breithaupt', with a long horizontal flourish extending to the left.

James R. Breithaupt, Q.C., M.P.P.,
Chairman.

November 1981.



PREFACE

The Select Committee on Company Law was reconstituted on May 25, 1976 under the following terms of reference:

“to continue the enquiry and review of the law affecting the Corporations in this province as reported on by the Select Committee of this House appointed on June 22, 1965 and re-appointed on July 8, 1966, on July 23, 1968 and December 17, 1971 and to, in particular, enquire into and review the law relating to the business of insurance companies in the province including but not restricted to,

- (a) the incorporation, licensing, regulation and supervision of insurers as joint stock companies, mutual corporations, fraternal societies, mutual benefit societies, exchanges, syndicates of underwriters and rating bureaus carrying on all classes of insurance business in this province, mergers, amalgamations and reinsurance of liabilities, reporting to shareholders, policyholders and members, their solvency, liquidity and financial requirements, the purposes, scope and functions of their returns, reports, statistical gathering, and the basis for their rates and premiums;
- (b) automobile insurance contracts and, in particular, the provision of accident benefits, fire insurance, accident and sickness and marine contracts and generally insurance contracts in this province;
- (c) the licensing, regulation and supervision of insurance agents, brokers and adjusters; and
- (d) the marketing of insurance in this province.

And that the Select Committee have authority to sit during recesses and the interval between Sessions and have full power and authority to employ counsel and such other personnel as may be deemed advisable and to hold meetings and hearings in such places as the Committee may deem advisable and to call for persons, papers and things and to examine witnesses under oath, and the Assembly doth command and compel attendance before the said Select Committee of such persons and the production of such papers and things as the Committee may deem necessary for any of its proceedings and deliberations, for which the Honourable the Speaker may issue his warrant or warrants.”

In order to examine the business of the insurance industry in this Province with reasonable care and thoroughness, the Committee has segmented its investigations into several fields of study. It was agreed to focus first on the field of general insurance and enquiry into this industry area resulted in the issue of three reports, two on automobile insurance and one on the remainder of the general insurance field. It was then agreed to focus on the

field of life insurance, other than accident and sickness insurance, and enquiry into this segment of the industry resulted in the issue of a report.

The Committee's First Report on Automobile Insurance was submitted to the Legislative Assembly on March 28, 1977 by the Chairman, Mr. Vernon M. Singer, QC. The Second Report on Automobile Insurance was tabled in the following year on June 22, 1978 by the newly appointed Chairman, Mr. James R. Breithaupt, QC. Mr. Breithaupt tabled the Third Report on General Insurance on June 12, 1979. The Committee's Fourth Report on Life Insurance was submitted to the Assembly a year later on June 19, 1980 by the continuing chairman Mr. Breithaupt.

On June 19, 1980, the Committee was reconstituted to conduct enquiry into the accident and sickness insurance field and resumed its hearings with the following fourteen appointed members: Mr. Breithaupt (Chairman), Messrs. Blundy, Cunningham, Germa, Hodgson, Laughren, Lawlor, Reid, Rotenberg, Smith, Sterling, Van Horne, Watson and Yakabuski. Messrs. Sterling and Watson resigned from the Committee and Messrs. MacBeth and Rollins appointed on December 12, 1980 to fill in the resulting vacancies. The announcement of a provincial election on February 2, 1981 ended the life of the Committee. On July 3, 1981, the Committee was reconstituted to complete its enquiry into the accident and sickness insurance field and resumed its hearings with the following twelve appointed members: Mr. Breithaupt (Chairman), Messrs. Cunningham, DiSanto, Hennessy, Kolyn, Mitchell, Pollock, Reid, Renwick, Sheppard, Taylor and Van Horne.

The Committee approached its most recent investigations through a series of public sessions. During the course of these sessions, the Committee learned from the industry, the Superintendent of Insurance, union representatives, employers, the Workmen's Compensation Board and other interested parties about various aspects of and concerns with medical care and income protection during periods of sickness and disability and the role of accident and sickness insurers and the non-profit prepaid medical care organizations in this field.

The Committee approached the first part of its meetings with industry representatives in a series of fact-finding sessions. These meetings lasted three days in early July, 1980 and were devoted to an overview presentation of the role of the private sector in matters relating to medical care, dental care and income protection during periods of disability prepared by The Canadian Association of Accident and Sickness Insurers. Additional information sessions were held during July. These sessions included visits to the premises of several organizations in Toronto providing accident and sickness insurance coverage. During these visits and at other sessions with industry participants it was the aim of the Committee to gain a perspective and sufficient information on the many components of the industry and its operations and

identify possible problems or concerns of both insureds and participants in the industry.

During July, 1980 the Committee also met with the Superintendent of Insurance, an employee benefit consultant, several employers and representatives of The Canadian Union of Public Employees. In September, the Committee met again with The Canadian Association of Accident and Sickness Insurers and union representatives including the Canadian Union of Public Employees. Further, in September, the Committee was particularly pleased to have an opportunity to meet with the representatives of The Workmen's Compensation Board, including its then newly appointed Chairman, the Hon. Lincoln M. Alexander, PC, QC. During its sessions the Committee also had an opportunity to hear from Professor Reuben Hasson and Associate Professor Edward Belobaba regarding some suggestions they have for improving the present disability financial protection system in Ontario. All of these sessions, together with meetings with representatives of the Ontario Medical Association, the Ontario Dental Association and others interested in various aspects of safety, sickness and accident prevention and rehabilitation, were most helpful to the Committee.

Since being reconstituted in June of 1980, the Committee has held public sessions on 22 days. There have been more than 95 witnesses before the Committee to discuss the operations of various aspects of disability financial protection and, in particular, the role of accident and sickness insurers and the non-profit prepaid medical care organizations in this area. A list of witnesses is set out in Appendix A. The Committee is indebted to all who contributed to the presentations at public hearings and to the submissions, exhibits and other documents received by the Committee during its enquiry. The Committee also extends its gratitude to those companies and associations who made arrangements for the Committee to visit their premises. With the assistance of the many witnesses appearing before the Committee, members were able to obtain a broad perspective of the operations of the disability financial protection system.

In addition to those who appeared before the Committee, our business consultants, Woods Gordon, contacted numerous other persons asking for their assistance in the Committee's investigations and in research work.

As in all its previous studies, the Committee is indebted to Mr. Murray A. Thompson, QC, Superintendent of Insurance of Ontario, for his contributions and those of his staff in assisting the Committee.

The work of the Committee could not have been accomplished so effectively without the assistance of our consultants, Woods Gordon, who contributed greatly to the preparation of all of our previous reports and to our Fifth Report. The Committee wishes to express its particular thanks to Mr. R. Paul Boddy, CA of Woods Gordon for his assistance in organizing the hearings and in the writing of the Report.

The Committee also wishes to express its special gratitude to Mrs. Frances Nokes, who has been Clerk of the Select Committee since it was first appointed. She has been most ably assisted by our secretary, Mrs. Frances Davidson.

PROVINCE OF ONTARIO
LEGISLATIVE ASSEMBLY
SELECT COMMITTEE ON COMPANY LAW

THE INSURANCE INDUSTRY
FIFTH REPORT ON
ACCIDENT AND SICKNESS INSURANCE

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INTRODUCTION

The Select Committee on Company Law is continuing its enquiry and review of the law relating to the business of insurance in the Province of Ontario by consideration of matters relating to accident and sickness insurance. In order to conduct its study of the business of insurance with reasonable care and thoroughness, the Committee had decided to defer consideration, as far as practicable, of accident and sickness insurance until now. The Committee recognized that a number of aspects of the operation of both life insurance companies and general insurance companies involve matters relating to accident and sickness coverages. As a consequence, there were references in the Committee's previous reports to some aspects of accident and sickness insurance and matters relating thereto. These references mainly concerned the accident benefits coverages provided in Policy Section B of the Standard Automobile Policy and to various riders on individual and group life policies. With these exceptions, the detailed study in the field of accident and sickness insurance was deferred for separate investigation because of the importance of this coverage to the residents of the Province.

The Committee's current review has been affected to some extent by several studies either currently being undertaken or recently completed in the Province of Ontario and Canada. The Royal Commission into the Confidentiality of Health Records, headed by the Hon. Mr. Justice H. Krever, submitted its report on September 30, 1980 to the Minister of Health for the Province and the report and its recommendations are presently under review. Likewise, the report of the Royal Commission on the State of Pensions in Ontario, headed by Miss Donna J. Haley, QC is being reviewed by a Select Committee of the Legislative Assembly and the entire matter of pensions as a national problem is being reviewed at the federal level. Another report, this time for the federal government was issued in November 1980 and concerned "Canada's National-Provincial Health Program for the 1980's". This report was prepared by the Hon. Emmett M. Hall, CC, QC and called for, as its sub-title indicated, "a Commitment for Renewal". Finally, Mr. Paul C. Weiler has submitted to the Minister of Labour for the Province of Ontario his first report on his study of workers' compensation in Ontario. This report deals with a number of observations and suggestions for "Reshaping Workers' Compensation for Ontario". The Committee has avoided duplicating the detailed enquiries undertaken by the Royal Commissions and by Justice Hall and Professor Weiler in their respective areas of study. However, the Committee has made use of these reports in the course of its enquiry.

The Committee has also noted with particular interest, and received permission to make reference to, observation made by the authors of "A Hit-and-Miss Affair—Policies for Disabled People in Canada", prepared by Joan C. Brown. This report has addressed a number of fundamental issues in matters relating to the financial protection of the disabled in Canada and has been very helpful to the Committee.

The Committee's report is divided into seven parts. The Committee's conclusions and recommendations appear in Part VI of the report and a summary of the Committee's recommendations are in the last chapter of that Part.

In Part I, the Committee provides an overview of medical care and income protection during periods of disability. Chapter I sets out the Committee's general view of the public interest in financial protection and makes reference to the Committee's previous reports concerning some aspects of this subject and then provides a necessary introduction to the balance of this Report. Chapter 2 reviews medical care coverage for residents of Ontario, dealing first with the basic protection provided by the Ontario Hospital Insurance Plan and then supplementary health care coverages provided by the private sector and special health care coverages provided under various government plans and social assistance programs. In Chapter 3, a similar review of dental care is made. Finally, in Chapter 4 the various government and private programs of providing for income protection during periods of sickness and disability are reviewed. These background chapters show the array of programs, both government and private, that make up the disability financial protection "system" in Canada and illustrate clearly that the accident and sickness insurance industry plays only a part in the providing of financial protection to the residents of Ontario in the case of disability.

In Part II, the Committee turns its attention to the role of the insurance industry and the non-profit prepaid medical care organizations in the disability financial protection system. In Chapter 5, the types of insurance coverage available to residents of Ontario and provided by the private sector are reviewed under the headings of medical care plans; dental care plans; plans for income protection during periods of sickness or disability and other accident and sickness insurance plans. In general these plans have been designed by the private sector to respond to the industry's perception of consumer needs to fill gaps in existing government plans. In Chapter 6, private organizations participating in the disability financial protection system are identified and an estimate of the volume of business they write is reviewed. In Chapters 7, 8 and 9 more particular discussions take place of certain aspects of medical care plans; dental care plans, and income protection plans including some aspects of risk selection, underwriting and claims handling procedures. Chapter 10 reviews briefly a number of other accident and sickness insurance plans provided by insurance companies. The marketing of insurance products is discussed in Chapter 11, dealing first with the marketing of group insurance, then individual insurance and finally, some aspects of mass marketing. Chapter 12 reviews briefly a number of other matters pertaining to the accident insurance business not dealt with in preceding sections, including such matters as reserving practices; self-insurance; confidentiality; and premium taxes. Finally, in Chapter 14 a few matters concerning the legislation and supervision of accident and sickness insurance that are unique to this field of insurance are reviewed.

In Part III, the Committee observes upon a number of matters concerning accident and sickness prevention and rehabilitation. In Chapter 14, an overview of the concerns with accident and sickness prevention and rehabilitation are discussed, followed in Chapters 15 and 16 with a review of the needs for safety and preventive programs and rehabilitation programs and the current responses in place in Ontario to these needs.

In Part IV, the Committee reviews some alternatives to the present system of disability financial protection for residents of Ontario. Chapter 17 provides an overview and a summary of the alternatives suggested by several witnesses who appeared before the Committee during its hearings. Chapter 18 then reviews a number of alternative systems in selected countries outside Canada, with particular emphasis on systems and studies relevant to financial protection for accident and sickness in New Zealand, Australia and the United Kingdom. Chapter 19 then reviews proposals for alternative systems in Saskatchewan and Manitoba where the implications of the federal system on the deliberations in these provinces is the same as faced by Ontario.

In Part V, in Chapter 20, the Committee deals with prepaid legal services in Canada, a matter that was raised before the Committee during its hearing which is not directly related to accident and sickness insurance but which must be dealt with in this, the Committee's last report on the insurance industry.

In Part VI, the Committee turned its attention to a discussion of the problems, gaps and anomalies in the present disability financial protection system and summarizes its conclusions and recommendations. Chapter 21 provides an overview of the concerns expressed by some of the Committee members and witnesses and outlines the basis of the discussion to follow. Chapter 22 then deals with matters concerning medical care and Chapter 23 with dental care. Before dealing with improving the present disability income protection system, Chapter 24 deals with a number of considerations and recommendations regarding a comprehensive disability income protection system which the Committee is convinced should be the goal for the Province. This chapter is followed in Chapter 25 with some suggestions and recommendations as to methods of improving the present system although the Committee makes it clear that it is loath to patch the present system and indeed does not believe that any patching can be done well. In Chapter 26, matters relating to rehabilitation and the duration and termination of income disability income protection are reviewed by the Committee, including its conclusions and recommendations. Chapter 27 then deals with matters relating to safety and prevention. Chapter 28 deals briefly with matters concerning the confidentiality of health information. The Committee's recommendations are summarized in Chapter 29.

Part VII of the report is a summary of observations on the Committee's review of the business of insurance in Ontario, during the five years of its

enquiry. In this Part the Committee reviews the themes of its reports; the types of recommendations it has made; and, the general responses to date by the Ministry, the Superintendent, and participants in the industry to its reports. The Committee concludes this Part with a comment on its concept of the changing role of the Superintendent of Insurance of Ontario.

PART I

OVERVIEW OF MEDICAL CARE AND INCOME
PROTECTION DURING PERIODS OF DISABILITY

CHAPTER I

Overview of the Public Interest in Financial Protection

A. INTRODUCTION

In the period since June 1976, the Committee has conducted an exhaustive study into a number of aspects of the business of insurance in Ontario. While the business of insurance is a broad one, its foundation is the theme of financial protection, to cover virtually all aspects of the protection of income and the protection of property.

There are many common aspects of the business of insurance, basic concepts that vary only in their application to individual products. The similarities range from the general manner in which insurance risks are assessed, products are priced, to the methods by which policies are marketed.

By their nature, all insurance products are intangible—the evidence of which is a legal document. For payment in advance, they call for the delivery of benefits at some future date. It is these considerations that, in the main, have made it necessary for governments to take a regulatory role in supervising the insurance industry in order to provide some assurance to consumers that the product as promised will be delivered.

While there are common ingredients among all types of insurance, there are, from the point of view of the consumer and his financial protection needs, many essential differences in the various types of insurance products and coverages. It was the complexity of the financial protection requirements of consumers and the insurance industry's responses to these perceived needs that led the Committee to segment its review by first studying matters relating to automobile insurance; then property and casualty insurance, other than automobile; then life insurance; and now "accident and sickness" insurance.

In its review of automobile insurance, one of the main recommendations of the Committee, which is now reflected in legislation, was that every person who owns a licensed automobile be required to have a valid policy of automobile insurance providing third-party liability coverage and accident benefit coverage. In this context, the Committee recommended that the alternative of "self-insurance" generally be eliminated. The Committee went on to conclude that the business of automobile insurance should continue to be conducted in Ontario by the private sector on the understanding that there is a fundamental need, particularly when a compulsory automobile insurance rule is involved, for a government presence in the supervision of the industry and this applies in particular to rate regulation. From the perspective of the consumers' needs for financial protection, the optional decision of whether to use the mechanism of insurance to spread the risk of a catastrophic loss has been removed by making insurance compulsory. In so doing, the private

sector automobile insurance industry has in effect been given a monopoly subject only to the overview of the Superintendent of Insurance of the Province.

As the Committee continued its review and turned its attention to property and casualty insurance, other than automobile insurance, it came to view the insurance system as an essential, attendant mechanism for coping with losses, exposure to which is inescapable by individuals. From the perspective of financial protection, insurance provides the opportunity to transfer risk of loss from individuals and organizations to a risk sharing pool wherein the premiums of the many are used to pay the losses of the few. The compulsory aspect of this portion of general insurance is less obvious but there is also the aspect of the necessity of insurance as being required by most persons to cope with accidental losses that can be of substantial proportions. From a practical point of view, the insurance product therefore becomes almost essential to individuals and organizations as the only practical alternative to self-insurance. This indispensable aspect of insurance coverage was one of the main reasons that the Committee, viewing the insurance contract as a product differing from most others by its intangible nature; and considering the consumer is likely to want some assurance that the insurance product will serve him well, that the Committee concluded some form of objective, government supervision over the provision and availability of the insurance product was a continuing necessity.

When the Committee turned its attention to the life insurance portion of the insurance business, it recognized that both the life insurance products providing death benefit coverage and annuity contracts could not be considered without reference to public expectations about financial protection or social security. The Committee recognized, however, that the life insurance product competes with a variety of alternative financial products and services to meet the needs of those concerned with providing financial support for themselves and their dependents even if they are disabled or do not live to fulfil that need and, in the case of annuities, of those concerned with providing income maintenance after retirement. While the life insurance industry has a monopoly on contracts involving life contingencies, the products of the industry are not unique in that there are alternative products and services available to citizens to meet the financial protection needs which life insurance products attempt to satisfy.

In its Fourth Report, the Committee noted:

“the spectrum of financial protection is a broad one ranging from income maintenance during sickness or recovery from accident, to income protection in the case of unemployment, to income maintenance for dependents in the case of death or disability, through to income maintenance after retirement. Included as well is the need to meet specific expenses such as medical treatment or death and burial expenses”.

It is against this background that the Committee conducted its review of the life insurance industry, other than accident and sickness, in that Report. It is against this background, as well, that the Committee now turns its attention to the accident and sickness portion of the business of insurance.

As the Committee commenced its review of accident and sickness insurance, it recognized that this segment of the insurance business was different again from other portions of the industry. The accident and sickness insurance industry plays only a part in the great number of plans designed to provide financial protection to the residents of Ontario in the case of disability.

The Committee further recognized that within the broad definition of insurance founded on the theme of financial protection to cover virtually all aspects of the protection of income and property, “accident and sickness” insurance among all of the insurance products is probably the most important to Ontarians.

B. OVERVIEW OF THE PUBLIC INTEREST IN ACCIDENT AND SICKNESS INSURANCE

The concerns of the public of Ontario as they relate to financial protection at the times of disability can be expressed simply—*essentially the public wants to be free of the worries of both the costs of medical care and income maintenance during periods of disability.*

In order to analyze the requirements of the residents of Ontario for financial protection during periods of disability in more detail and to study the manner in which the public and private sectors have responded to these needs, the Committee has throughout this Report tried to isolate matters related to medical care, dental care and income protection for individual review. With this approach, the Committee believes it has been able to obtain a better understanding of the main components of the financial protection needs of consumers; to isolate problems, gaps and anomalies in the system more precisely; and, to reach its conclusions and recommendations in regard to these matters logically.

Brief general comments follow concerning the public interest in each of these areas of review—medical care, dental care and income protection.

Medical Care

Nearly everyone needs medical care during his or her lifetime. From birth through childhood and maturity to old age each Ontarian will likely require the use of medical care facilities, professional medical services, ancillary medical services and drugs. The need for medical care may be of short-term duration, may be longer term involving convalescence or may be very long-term as in the case of severe sickness or disability or an incurable

infirmity. Medical care may be required not only in the case of physical problems but in cases of mental or emotional disorder. The facilities necessary for purposes of medical care include not only hospitals but also other institutions. Professional care may be provided in these facilities, in professional offices, in the home or elsewhere by various types of professionals expert in medicine, surgery, dentistry, psychiatry and so on. Ancillary services may involve nursing services and assistance of many other kinds once again provided either in hospitals or other institutions, in professional offices, at home or elsewhere. Medical care also involves the provision of drugs and other medication either at the hospital, an institution or at home. Medical care includes as well various devices to overcome or alleviate physical problems and would include such items as prosthetic devices, crutches, hearing aids and glasses. Ambulance and other transportation to and from hospitals and other facilities providing medical care are also part of the total.

The concerns of the public for financial protection to defer the costs of medical care are not related to the reason for the need for medical care. The need for medical care at the time of birth, for birth defects, during childhood and adolescence, during maturity and old age do not change. It is irrelevant in the eyes of the public whether the needs for medical care are hereditary or result from one of the so-called "common" ailments, or result from accidents or other mishaps at work, while on public transport, in an automobile accident, in the home, while at recreation, as a result of criminal activities or are even self-inflicted.

Dental Care

The majority use the services of the dental profession at some time. While the emergency nature of the needs of most is not as pressing as is generally the case for medical care, the advantages of "regular visits to the dentist" are well publicized. There are, of course, situations when immediate attention is required. At the other end of the spectrum, there are some dental services which are discretionary and, in the view of some, merely cosmetic.

The concerns of the public for financial protection to defer the costs of dental care regardless of the particular services involved are simply that they want to be untroubled about the costs of the services at the time they are performed.

Income Protection During Periods of Disability

The public's concern with disability financial protection includes not only concern regarding protection against the costs of medical and dental care but also concern for protection against loss of income during periods of disability. The Committee, during its review, has attempted generally to segregate the aspect of income protection from matters related to medical and dental care.

The scope of income protection during periods of disability and recovery is broad when viewed in the context of the various types of persons that must be covered—wage and salary earners and their dependents; the self-employed and their dependents; non-earners—children, students and homemakers; as well as the elderly. In addition to the types of persons that must be considered, the Committee recognizes that the duration of incapacity adds to the complexity of the subject since the period of disability may range from very short-term, to life long confinement because of the incurable nature of the disability. Further, the Committee has noted that the subject of income protection can be complicated by the views held by some of the importance of awards for injuries suffered, of replacement of services of homemakers that may be lost and, of income protection either partial or whole during the periods of rehabilitation.

C. THE PRESENT DISABILITY FINANCIAL PROTECTION SYSTEM IN ONTARIO

As has been stated, the wants of the public as they relate to financial protection during periods of disability are quite simple. The public wants financial protection to include income protection and protection against the costs of medical care.

It became clear to the Committee during its review that there is no overall “system” as such for disability financial protection in operation in Canada and Ontario. The proliferation of ad hoc plans that do exist at least, in total, ensure that most will not go without medical care. In the case of loss of income some will need to rely on social assistance to provide minimum support.

A random listing of the sources of financial protection during periods of disability is, on the one hand, impressive and on the other hand both confusing and complex. Included among others are:

- the protection provided from accumulated personal or family resources;
- voluntary payments by employers;
- negotiated sick pay and/or wage and salary continuance programs;
- unemployment insurance benefits;
- short-term insured weekly-indemnity programs;
- short-term employer or employer/employee administered weekly-indemnity programs;
- long-term income maintenance plans both insured and self-administered;
- group life insurance;
- Canada Pension Plan disability benefits;
- private pension plan disability benefits;
- workers’ compensation;

- Ontario Health Insurance Plan (OHIP);
- supplementary health care coverage;
- personal insurance for specific purposes—in the case of cancer or to defer costs of replacement staff or services;
- creditors' group insurance;
- waiver of premium riders on life policies;
- successful court action;
- disabled and blind person's allowances;
- veterans' disability pensions;
- compulsory automobile accident benefit insurance;
- compensation for criminal injuries;
- income tax deduction for medical expenses;
- social assistance.

In the following chapters of this Part an overview of the various public and private plans that make up the "system" of disability financial protection for Ontarians is presented. Any review of this type is bound to be subject to some deficiencies but it has been designed to provide a reasonable perspective of the various plans now in place in the Province and available to residents of Ontario. In Chapter 2, the available medical care coverage is summarized; in Chapter 3 dental care coverage is reviewed; followed in Chapter 4 with a review of the various income protection programs and plans.

CHAPTER 2

Medical Care Coverage

A. INTRODUCTION

The purpose of this chapter is to present an overview of the present sources of medical care protection available to citizens of Ontario. As noted in Chapter 1, “medical care” as used throughout this Report covers the use of hospital and other institutional facilities; professional services; nursing and similar services; ambulance transportation; drugs and other medication; and, the provision of devices, such as, prosthetic devices, to help overcome physical disabilities.

In general, residents of Ontario have access to financial protection against a significant portion of the costs of medical care. Basic protection for residents both while in Ontario and when travelling is available through the Ontario Health Insurance Plan (OHIP). However the complete range of medical care is broader than that covered by OHIP. It is from the perspective of the whole that this chapter attempts to view the subject of medical care coverage.

There are some residents by dint of circumstances of employment and/or cause of their confinement who are protected against all medical care costs. Others are able to “insure” most medical care costs not covered by OHIP. There are also those who do not choose to purchase OHIP coverage and use their personal resources to pay the costs of all medical care. At the opposite end of the spectrum there are those who cannot afford to pay the OHIP premiums and who have the OHIP services provided free. If these people need care not covered by OHIP they must rely on social assistance programs.

The review of medical care coverage available in Ontario in the remainder of this chapter is set out under the following headings:

- Ontario Health Insurance Plan
 - in which eligibility, insured services, and other matters related to the operations of OHIP are summarized.
- Personal resources
 - in which the circumstances when residents use their own resources to pay the costs of medical care are discussed.
- Supplementary health care coverage
 - reviews briefly coverages provided by non-profit prepaid medical organizations and insurance companies, a subject which is reviewed in detail in Part II of this Report.

- Special health care coverage
 - concerns eligible workers covered by workers' compensation; victims of automobile accidents; war veterans; and victims of criminal injury.
- Social assistance
 - reviews briefly the medical care coverage under social assistance programs.
- Miscellaneous government programs
 - notes a number of other medical care related programs available in Ontario.
- Tax relief for medical care costs
 - summarizes some aspects of tax relief to alleviate some of the costs of medical care.

B. ONTARIO HEALTH INSURANCE PLAN

A Brief History of Health Insurance in Ontario

Prior to 1941 when the Ontario Hospital Association launched its Blue Cross Plan for Hospital Care, very little was available to the residents of Ontario insofar as health insurance protection was concerned. Commercial insurers had not entered the field to any great extent, although a few carriers had limited plans of protection for select groups. Ontario's Blue Cross Plan, which began on March 17, 1941, was patterned after similar prepaid hospital insurance plans which began to spring up in the United States during the thirties. This non-profit plan enjoyed wide public acceptance in Ontario and by the end of 1958 had approximately 43% of the people insured. Private insurance companies who, by this time had become more involved in the field, were covering, in total, about the same proportion of the population leaving something less than 20% of the people without some form of hospital care insurance.

After World War II, hospital costs and utilization rates began to rise and Blue Cross had to increase its subscription rates about every two years. Public demand then arose for the government to become involved in the field of hospital insurance. Eventually, all political parties were committed to the introduction of hospital insurance and the then Prime Minister of Ontario, Hon. Leslie Frost, proposed to the federal government in 1955, that it participate in the cost of a national plan to be operated by each province. The result of this was the Federal/Provincial Agreement under which the Government of Canada pays 50% of the cost of insured services across Canada.

In May 1956, the provincial government established the Ontario Hospital Services Commission to administer the Ontario Hospital Insurance

Plan which was to begin operating on January 1, 1959. Under the Hospital Services Commission Act, the Commission was also charged with responsibilities related to the development of Ontario's hospital system and the administration of hospital legislation.

Having overcome the problem of hospital expense, the spotlight then fell upon medical bills which were the next most serious problem in the cost of health care. In the mid-sixties the federal government had not yet decided to subsidize the cost of provincial medical plans so Ontario, primarily, to meet the needs of those unable, because of age or physical condition, to obtain insurance against medical costs, established the Ontario Medical Services Insurance Plan, known more briefly as OMSIP. OMSIP began to function on April 1, 1966 on behalf of designated social assistance recipients and their eligible dependants and, on July 1, 1966, for all those persons who had applied voluntarily for this protection during an open enrolment period which ran from March 1 to May 16 of that year. OMSIP operated as a complementary measure to the existing non-profit and commercial plans and, in doing so, fulfilled an important function until federal subsidies for a universal medical insurance program became available. Unlike the hospital insurance program, OMSIP was operated, not by a Commission, but as a function of the Department of Health.

As of July 1, 1968, the federal government began contributing toward the cost of medical insurance in the provinces under certain conditions and, in July 1969, the provincial government announced its intention to participate in the federal program and to replace OMSIP as of October 1 of that year, with a universal plan which would pre-empt the field of medical insurance for the government, and make the same broad protection available to all residents. It was at this time that the name OMSIP, for Ontario Medical Services Insurance Plan, was changed to OHSIP, the acronym for Ontario Health Services Insurance Plan. The reason for changing the term "medical" in the name to "health" was basically because the new program included additional benefits for the services of such health practitioners as chiropractors, osteopaths and chiropodists.

Ontario now had two universal health insurance programs—Ontario Hospital Insurance, and OHSIP with a central plan assisted by some forty private insurers who acted as designated agents. There was also the Health Insurance Registration Board which was the enrolment and collection agency for the hospital and medical insurance programs.

The government wanted to combine these two programs into one health insurance plan under which the residents of this Province could have the total package of protection for one premium, with one insurance number, one identification card and uniform terms and conditions. This was accomplished by replacing the former programs with the Ontario Health Insurance Plan which took effect on April 1, 1972.

The Federal and Ontario Legislation

Government health insurance in Canada has evolved in recent years under the federal-provincial cost sharing arrangements legislated by the Canada Medical Care Act, 1966-67.

Under this Act, insured services are defined as:

“all services rendered by medical practitioners that are medically required, except any services that a person is eligible for and entitled to under any other Act of the Parliament of Canada or under any law of a province relating to workmen’s compensation.”

To be eligible for the federal contribution to shared costs for insured services under this Act, a provincial plan must meet the following criteria:

- “(a) the plan is administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province . . . that is responsible in respect of the administration and operation of the plan to the government of the province or to a provincial minister designated by the government of the province for such purpose, and that is subject in respect of its accounts and financial transactions to audit by such person as is charged by law with the audit of the accounts of the province;
- (b) the plan provides for and is administered and operated so as to provide for the furnishing of insured services upon uniform terms and conditions to all insurable residents of the province, by the payment of amounts in respect of the cost of insured services in accordance with a tariff of authorized payments established pursuant to the provincial law or in accordance with any other system of payment authorized by the provincial law, on a basis that provides for reasonable compensation for insured services rendered by medical practitioners and that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons;
- (c) the number of insurable residents of the province who are entitled under the plan to insured services is not less than 95% of the total number of insurable residents of the province, . . . ; and
- (d) the plan does not impose any minimum period of residence in the province or any waiting period in excess of three months before persons who are or become residents of the province are eligible for or entitled to insured services, and the plan provides for and is administered and operated so as to provide for the payment of amounts in respect of the cost of insured services furnished to insured persons while temporarily absent from the province, and in

the case of persons who have ceased to be insured persons by reason of having become residents of another participating province, of the cost of insured services furnished to such persons during any minimum period of residence or waiting period imposed by the medical care insurance plan of that other province, on the same basis as though such persons had not been absent from the province or had not ceased to be residents of the province, as the case may be.”

Government health insurance in Ontario is now governed under the Health Insurance Act, 1972. The plan is called the Ontario Health Insurance Plan (OHIP).

Persons Eligible to be Insured

Every resident of Ontario is eligible to enroll in OHIP. Tourists, transients, Canadian students from other provinces, and visitors to Ontario are not. Every defined dependant of an insured person is an insured person. Insured persons are entitled to payments for insured services during periods in which premiums have been paid or forgiven.

Insured persons leaving Ontario temporarily may arrange to continue in the plan. Those leaving permanently may continue coverage until other coverage becomes effective or for up to four months, whichever comes first.

In special medical cases and for senior citizens, OHIP coverage is available while residing out of Ontario provided that such persons are residents in Ontario for four consecutive months each year and make application to OHIP advising of the circumstances for their absence.

Dependant Coverage

The family premium covers husband and wife, and children under the age of 21 years who are: unmarried, not employed, and dependent for support upon the insured person. This would also include an adopted child or one to whom the insured person stands in the position of a parent and for whom deduction for income tax purposes can be claimed.

Also eligible as dependants are children aged 21 and over who are financially dependent upon the insured person because of physical or mental infirmity, provided each such child was financially dependent upon that person prior to the age of 21. This does not, however, include the spouse of such a child.

Methods of Enrolment

Participation in the Ontario Health Insurance Plan is on a group or individual basis, as follows:

Employed groups—

Persons employed where there are 15 or more on the payroll, including the employer, must be enrolled by the employer or properly exempted from the group.

This also applies to persons employed where there are from 6 to 14 on the payroll and the employer has elected to enrol his employees as a mandatory group.

“Collector” groups—

Group enrolment is also available to organizations such as professional groups, associations, farm groups and co-operatives which wish to form groups and remit premiums on behalf of their members. Participation in such groups is voluntary.

Individual enrolment—

A resident who is not connected with a mandatory employed group may enrol and pay premiums directly to the plan on a quarterly basis.

Effective Date of Coverage

Present Ontario residents—

Coverage begins on the first day of the third month following the date of joining an insured group or of application for individual enrolment.

Former residents of other Canadian provinces or territories—

Persons moving from another Canadian province or territory to take up permanent residence in Ontario become eligible for OHIP coverage on the first day of the third month following their arrival in Ontario, or on the expiry date of their former coverage, whichever is the later. If application is not made before the first day of the third month following arrival in Ontario, coverage will not be effective until the first day of the third month following the month in which application is made.

Landed immigrants and others—

Coverage will begin on the first day of the month following the day applications are approved for persons such as: landed immigrants, foreign students, Canadians returning to Canada to be residents of Ontario; and for persons discharged from the: Canadian forces or RCMP, Canadian penal or correctional institutions, or Ontario psychiatric facilities; provided they apply within a specified period, normally 30 or 90 days after arrival in Ontario or from the date of discharge for example, 30 days in the case of those discharged from the Canadian forces and 90 days for landed immigrants.

Premiums

Premiums are payable in the third month prior to the benefit month to which they apply. Groups remit each month. Persons enrolled on an individual basis pay quarterly, three months in advance of the applicable benefit period.

The January 1981 premium rates were:

	Monthly	Quarterly
—Single (one person)	\$20	\$ 60
—Family (two or more eligible persons).....	\$40	\$120

The Act defines the responsibilities of the employer and each employee regarding payment of premiums as follows:

- “(4) The employer shall deduct from the remuneration of each employee in his mandatory group the premiums required under this Act or such part as is agreed upon by the employer and his employee, but each member of the group is primarily liable to pay the premium.
- (5) The deduction by an employer for the remuneration of an employee in his mandatory group of the premium required under this Act shall discharge the primary liability of that employee to pay the premium so deducted.”

Premium Assistance Available

A reduced income or financial difficulties need not prevent a resident from having Ontario Health Insurance. The following assistance is available for persons who have lived in Ontario for at least 12 months immediately prior to applying for premium assistance or senior citizen coverage.

Full premium assistance—

- Upon approval of the application for assistance, OHIP is provided without cost to applicants, if:
 - They are enrolled as single and their taxable income is in the qualifying range.
 - They are enrolled for family coverage and the combined taxable income of the applicant and spouse is in the qualifying range.

Partial premium assistance—

Applicants will be required to pay only one quarter, one half or three quarters of the regular premiums if they fall into the applicable taxable income bracket, and the application is approved:

Temporary premium assistance—

The purpose of temporary assistance is to provide premium-free Ontario Health Insurance coverage for persons who are temporarily unable to pay the required premiums as a result of unemployment, illness, disability or financial hardship, and who do not qualify for any other form of total premium assistance.

Social assistance—

Premium-free OHIP coverage is available to persons who qualify for assistance through the Ministry of Community and Social Services or through their local municipal welfare office.

No premiums for senior citizens—

Ontario Health Insurance premiums are not required for residents of Ontario 65 years of age or over. In the case of married couples, if one spouse is under age 65 but the other is over, the insurance may be transferred to the name of the older spouse, in order to qualify for premium-free insurance. The free insurance also provides coverage for eligible dependents.

Residents who turn 65 and have applied to OHIP become eligible for free coverage on the first day of the month in which their 65th birthday occurs.

Insured Services Within Ontario

The professional services of physicians and other health practitioners included in the plan are available when the person providing the service is duly licensed to practise that profession in the area where the service is received.

Ontario Health Insurance benefits are also available for medically necessary services received in approved hospitals. These include public general hospitals, hospitals for convalescents and the chronically ill, and Ontario psychiatric hospitals. Benefits are also provided in most private hospitals, but not in health spas and other similar facilities.

Physicians' services—

The insured person has the right to choose his own physician or practitioner. The physician or practitioner has no obligation to treat an insured person.

The plan pays benefits based on an OHIP approved schedule of fees arrived at after discussion with the Ontario Medical Association for all physicians' services that are medically required. These services include:

- physician's services in the home, the physician's office, the hospital or institution;

- services of specialists certified by the Royal College of Physicians and Surgeons of Canada;
- diagnosis and treatment of illness and injury;
- treatment of fractures and dislocations;
- surgery;
- administration of anesthetics;
- x-rays for diagnostic and treatment purposes;
- obstetrical care, including prenatal and postnatal care;
- laboratory services and clinical pathology when ordered by and performed under the direction of a physician.

Hospital Services—

For an insured patient treated at an approved hospital by a licensed physician, the plan covers the cost of the following hospital services, when medically necessary in the diagnosis and treatment of the illness or injury, on an in-patient or out-patient basis:

- standard-ward accommodation;
- necessary nursing services, when provided by the hospital;
- laboratory and x-ray diagnostic procedures;
- drugs prescribed by a physician, except when the hospital visit is solely for the administration of drugs;
- use of operating and delivery rooms, anesthetic and surgical supplies;
- use of radiotherapy facilities;
- services rendered by any person paid by the hospital.

In addition, plan benefits are provided for the following services when prescribed by a physician as a medically necessary course of treatment, and provided in Canada by approved hospitals:

- occupational therapy;
- physiotherapy-physiotherapy is also covered in Ontario in private non-hospital facilities approved by the plan when prescribed by a physician;
- speech therapy;
- out-patient diet counselling.

Extended health care—

Where an insured person, who has been residing in Ontario for one year or longer, requires continuing nursing service and regular medical supervision in a participating nursing home or home for the aged, the plan will provide benefits toward the standard-ward costs of such care. Eligible patients will be required to pay a portion of the daily standard-ward costs as established by legislation, plus any additional charges for a private or semi-private room.

Home care—

Certain patients whose physicians prescribe additional health care services may be able to have these services provided in their homes. Such services could be needed instead of admission to a hospital, or following early discharge from hospital. To be eligible for this benefit, the patient must require limited daily care by a health professional. An insured person who qualifies for such home care through an organized home care program in Ontario will not be charged for these services.

Ambulance services—

If the use of an ambulance is medically necessary, an insured person is required to pay only the following:

- a fixed fee for a land ambulance trip of 25 miles or less, plus a mileage rate for each mile over 25 miles, with a fixed maximum for one trip;
- a fixed fee for an authorized air ambulance trip including the cost of connecting land ambulances.

To qualify as an OHIP benefit, a land ambulance must be supplied by a licensed ambulance service, and its use must be confirmed as having been essential by a physician, a designated hospital official or another authorized person. In the case of a road accident, a police officer may authorize the use of an ambulance. Use of an air ambulance in Ontario must have prior approval by the Director of Ambulance Services Branch, Ontario Ministry of Health, or by another authorized person.

Dental care in hospitals—

Dentists' fees, for a specified list of procedures, are covered based on an OHIP approval schedule of fees arrived at after discussion with the Ontario Dental Association when:

- provided for an in-patient; and
- performed in an approved hospital; and
- performed by a dental surgeon who is a member of the hospital's staff.

Hospital charges for the above services are also covered.

Optometrists—

Optometric services, when rendered by an optometrist, are insured benefits under the plan. These services are paid based on OHIP approved fee rates.

Drug plan—

Ontario's drug benefit applies to all persons aged 65 years and over who have resided in Ontario for the past 12 months and either are

Canadian citizens or landed immigrants. Those eligible are able to receive any of the more than 1,700 prescription medicines covered by the drug benefit. All drugs must be prescribed by a physician, dentist or other qualified health practitioner.

Only the drugs listed in the Ontario Drug Benefit Formulary are supplied free of charge and all prescriptions must be filled in Ontario.

Other health services

The plan will provide benefits for other essential services as follows:

- a) Chiropractic services rendered in an office, institution or home are covered to an annual maximum per person, including a maximum for related x-ray examinations.
- b) Osteopathic services rendered in an office, institution or home are covered to an annual maximum per person, plus a maximum for related x-ray examinations.
- c) Chiropodist (podiatrist) services rendered in an office, institution or home plus independent minor procedures are covered to an annual maximum per person, plus a maximum for related x-ray examinations.

Out-of-province Coverage

The plan pays for medical and hospital care anywhere in the world for insured services as follows:

Hospital services—

Insured benefits for hospital emergency in-patient or out-patient treatment are payable at the rates charged. The plan pays the full hospital standard-ward charges for medically necessary care in a hospital acceptable to the plan anywhere in the world. Where an insured person receives non-emergency or elective care, which could have been received in Ontario the plan pays 75 percent of the hospital's charges for insured services.

Medical, dental and other services—

Insured benefits for physicians' treatment whether in or out of hospital will be paid at the rates applicable in Ontario. Those who provide medical services outside the province are not bound to recognize these rates. The insured is responsible for payment of any difference between the out-of-province bill and the amount allowed by the plan.

Ambulance services—

If the use of a land or air ambulance is medically necessary, the plan

will partially reimburse the cost. The amount of reimbursement will not exceed 75 percent of the actual cost, or the amount the plan would pay for the same services in Ontario, whichever is less.

Mental Illness

Mental illness is covered in Section 52 of the Act, part of which is reproduced below:

- “52. (1) In this section, “hospital” means a sanitarium licensed under The Private Sanitaria Act that is approved by the Minister for the purposes of this section, a children’s mental health centre under The Children’s Mental Health Centres Act, a hospital under The Children’s Mental Hospitals Act, a hospital established or approved under The Community Psychiatric Hospitals Act, a psychiatric facility under The Mental Health Act, or an institution designated an approved home or residential unit under The Mental Hospitals Act.
- (2) An insured person who is entitled to insured services under this Act and the regulations and who is admitted to a hospital under this section is entitled to such services as are required for his maintenance, care, diagnosis and treatment in accordance with this Act and the regulations without being required to pay or have paid on his behalf any additional premium or other charge beyond that necessary to entitle him to insured services under the Plan.
- (3) Notwithstanding subsection 2, an insured person in respect of whom, but for this Act, the Government of Canada would have assumed the cost of the maintenance, care, diagnosis and treatment provided under this section is not entitled to receive insured services in a hospital as an insured person.

Services Not Covered

The following are services *not* covered by the OHIP plan:

- Any hospital charges for private or semi-private accommodation;
- Hospital visits solely for the administration of drugs;
- Charges for dental care except as specified;
- Eyeglasses, artificial limbs, crutches, special braces and other such appliances;
- Private-duty nursing fees;
- Drugs taken home from the hospital;
- Transportation charges other than approved ambulance service;

- Medical examinations or certificates required for applications for employment or the continuance of employment, life insurance, or admission to camps or recreational activities;
- Cosmetic surgery; as defined by OHIP as being:

“Cosmetic Surgery refers to services for the purpose of beautifying the body or improving the physical appearance where there is no health related effect. Health related effects include physical health and mental or emotional health. The latter would be determined by the physician or psychiatrist treating the patient. Cosmetic surgery includes procedures such as face-lifts, and changing the shape of a nose.”;
- Acupuncture;
- Any health service other than those provided by approved hospitals or practitioners as specified.

Methods of Payment of Medical Bills

All claims must be submitted within six months of the services rendered. Medical bills are paid in several ways.

Hospital bills—

For care in an approved hospital anywhere in Canada, the plan will make direct payment to the hospital for insured hospital services. Also, the plan will deal directly with any hospital outside Canada that is willing to submit an insured patient's account directly to the plan.

Professional practitioners' bills—

Most Ontario physicians and optometrists have elected to submit claims for insured services directly to the plan and to accept the plan's allowances as full payment. If physicians or optometrists have chosen to bill their patients, they will complete a “pay subscriber” claim card to be forwarded to the nearest OHIP office by their offices or by the insured person. In such cases the insured person is responsible for any difference between the amount allowed by the plan and the amount charged.

As at April 30, 1980 approximately 17% of all doctors in Ontario have chosen to “opt out” of OHIP. OHIP publishes a quarterly listing of doctors who participate in OHIP. The listing changes frequently as doctors are constantly changing their stance. Certain doctors may “opt-out” for their personal practice and “opt-in” for their hospital practice. The number of doctors “opted-out” is not consistent as to communities or regions of Ontario, nor is it consistent as to specialties.

Other health practitioners may or may not bill the plan directly for

insured services. In either case the insured person is responsible for any difference between the amount allowed by the plan and the amount charged by the practitioner.

Ontario physicians must comply with Regulations under The Health Disciplines Act, 1974, which defines “professional misconduct” as including:

- a) Requiring payment for an insured service under OHIP, as a condition to be met before completing a claim card;
- b) Requiring payment for an insured service under OHIP, before providing an itemized account of the services;
- c) Charging a fee that is in excess of the fee listed in the current Ontario Medical Association fee schedule, without prior notification to the patient as to the excess amount of the fee.

Payment for medical, dental or other services outside Ontario is a direct transaction between the insured person and the physician or other practitioner. Usually the insured person pays the physician and subsequently applies for reimbursement from OHIP. The insured is responsible for payment of any difference between the out-of-province bill and amount allowed by the plan.

Ambulance services—

Ontario ambulances are supplied by licensed municipal, hospital, private, or volunteer ambulance services. If the trip starts or ends at a hospital, the hospital will bill the patient’s share. Otherwise, billing is done by the ambulance service concerned. Payment receipts for approved air ambulance services are submitted to OHIP.

To obtain reimbursement for out-of-province land or air ambulance services, the insured person must supply:

- a detailed statement showing the number of miles the patient was transported; and
- a certificate from a medical practitioner stating that the ambulance services were justified on medical grounds.

Relationship of OHIP With Other Government Health and Medical Care Coverage in Ontario

The Health Insurance Act identifies other Acts where health and medical care are directly provided, and specifies their relationship to OHIP as follows:

“‘insured services’ means such services of hospitals and health facilities as are prescribed by the regulations, all services rendered by physicians that are medically necessary and such other health care services as are rendered by such practitioners and under such conditions and limitations as are prescribed by the regulations, but not including the services

that a person is entitled to under The Workmen's Compensation Act, The Homes for Special Care Act or under any Act of the Parliament of Canada except the Hospital Insurance and Diagnostic Services Act (Canada) and the Medical Care Act (Canada)."

Subrogation to OHIP

In circumstances where services rendered under one Act are applicable under another Act, subrogation may apply. Funds may be transferred between plans; the right to bring legal action may or may not be exchanged.

The Ontario Health Insurance Act, 1972 defines circumstances where subrogation is allowed including the following:

- "35. (1) Where, as the result of the negligence or other wrongful act or omission of another, an insured person suffers personal injuries for which he receives insured services under this Act, the Plan is subrogated to any right of the insured person to recover the cost incurred for past insured services and the cost that will probably be incurred for future insured services, and the General Manager may bring action in the name of the Plan or in the name of that person for the recovery of such costs.
- (2) For the purpose of subsection 1, the payment by the Plan for insured services shall not be construed to affect the right of the insured person to recover the amounts so paid in the same manner as if such amounts are paid or to be paid by the insured person.
- (3) For the purpose of this section, the cost of insured services rendered to an insured person in or by a hospital or health facility shall be at the rate charged by the hospital or health facility to a person who is not an insured person.
37. The Plan is not an insurer within the meaning of The Insurance Act, as referred to in section 21 of The Motor Vehicle Accident Claims Act, and may be awarded payment from the Motor Vehicle Accident Claims Fund."

Representatives of OHIP have explained to the Committee that when OHIP has made payments in certain incidents they will seek recovery through subrogation.

"Examples include:

- against the Workmen's Compensation Board for payments subsequently determined to relate to a WCB claim.
- against third-parties for payments subsequently determined to relate to negligence.

- against motor vehicle insurers for out-of-province registered automobiles/drivers, and for incidents in other jurisdictions (Spain, France, U.K., U.S.A. etc.), subject to inter jurisdictional agreements.
- against Ontario insured motor vehicles insurers—in this case, subrogation payments are determined by formula rather than for each individual incident.
- against self-insured motor vehicle operators, such as the TTC, CN, CP, Toronto Star, Pepsi Cola.
- against other government departments operating vehicles, for example, Department of National Defence (self-insured) Department of Transport (carry insurance).
- against Motor Vehicle Accident Claims Fund which covers cases of stolen cars, uninsured vehicles in violation of the compulsory coverage.
- against physicians and/or hospitals for negligence; this could include a federal hospital which happens to be treating a patient covered by OHIP.”

C. PERSONAL RESOURCES

It is the intent of the Ontario Hospital Insurance Plan to be a universal medicare program providing the basic medical care needed by the citizens of Ontario. The plan is available to all residents of Ontario except those few who are ineligible to enrol, mainly because they are in the Province temporarily.

Since OHIP coverage is not compulsory, some will not have coverage—by personal choice, tardiness in application or ignorance of the availability or the desirability of coverage. When they or their dependants require medical care, these people must look to their own personal resources in the first instance to see them through.

Beyond the basic OHIP coverage, all other residents, unless they qualify under some other program, as discussed later, must use their own resources to pay medical care costs not covered by OHIP. In addition, all are responsible for the difference between a professional practitioner's fee and the OHIP payment, since The Health Services Act prohibits coverage by others of any insured services covered by OHIP.

Some of the items not covered by OHIP such as vitamins, salves, aspirins, etc. are considered by most as household expense rather than medical expenses in spite of their “medical nature”. Likewise, some medical care, such as, home care for a cold, is usually looked on as an unavoidable inconvenience. Thus there will likely always be some “medical care” costs to be borne by most out of their personal resources.

There remain, however, other more important and costly items not covered by OHIP. Items that if required to be paid from current income or the savings of most would be a heavy financial burden. It is for these items that many look to “insurance” as a source of financial protection. The non-profit prepaid medical care organizations and insurance companies have developed coverages to respond to these needs.

D. SUPPLEMENTARY HEALTH CARE COVERAGE

The Health Insurance Act, 1972 limits other health insurance coverage in Ontario as follows:

- “19. (1) Every contract of insurance, other than insurance provided under section 231 of The Insurance Act, for the payment of or reimbursement or indemnification for all or any part of the cost of any insured services other than,
- (a) any part of the cost of hospital, ambulance and nursing home services that is not paid by the Plan;
 - (b) compensation for loss of time from usual or normal activities because of disability requiring insured services.
- performed in Ontario for any person eligible to become an insured person under this Act, is void and of no effect in so far as it makes provision for insuring against the costs payable by the Plan and no person shall enter into or renew such a contract.
- (2) A resident shall not accept or receive any benefit under any contract of insurance prohibited under subsection 1 whereby he or his dependents may be provided with or reimbursed or indemnified for all or any part of the costs of, or costs directly related to the provision of any insured service.”

Some exceptions to the above are applicable to Ontario residents working in the United States, and to new residents for the first three months of Ontario residency. However, in general, no contract of insurance can be made to cover OHIP insured services.

The services not provided by OHIP were listed on page 23. A number of insurance companies and non-profit prepaid medical care organizations provide extended health care coverage for some of these services. Coverage is available to eligible subscribers on a group and sometimes individual basis for:

- differentials for the extra cost of semi-private and private accommodation at hospital,
- nursing home care,
- services through a plan medical centre,
- prescription drugs, serums, injectibles, insulin,
- dental care,

- hearing care and hearing aids,
- vision care and eyeglasses,
- special duty nursing,
- local ambulance services,
- appliances, including artificial limbs, braces, trusses and boots,
- wheelchairs and walkers,
- health care outside Ontario and outside Canada,
- health care for visitors to Canada.

Coverage under most supplementary health care plans involves a deductible and possibly co-insurance beyond the deductible. In addition, pre-existing conditions or specific conditions may be excluded from coverage in some agreements.

The coverage provided by insurance companies and non-profit prepaid medical care organizations under their extended health care plans are discussed in detail in Part II of the Report.

E. SPECIAL HEALTH CARE COVERAGE

In addition to OHIP and supplementary health care coverage, some Ontario residents under specific conditions may be able to obtain from other sources medical services or financial protection against all or substantially all the costs of medical care. These would include:

- eligible workers injured on the job and covered by workers' compensation,
- victims of automobile accidents,
- war veterans eligible to receive some services through Veterans Canada, and
- victims of criminal injury.

Each of these situations is discussed briefly.

Eligible Workers Covered by Workers' Compensation

In general, workers' compensation covers all employees working in specified industrial operations. Eligible workers are covered for their own medical and hospital expenditures arising from occupational injury or disease received while on the job. Some employees and groups of employees are excluded from coverage. Domestic servants in private dwellings, and many of the self-employed are excluded as are most casual workers. Farm workers are covered in Ontario. Employees working in a purely clerical-type operation as in a chartered bank or an investment firm, are not required to be covered, but may be if the employer applies to have them included. Senior executives do not usually elect to be covered by workers' compensation.

The features of medical care through workers' compensation are—

- coverage includes medical, surgical and dental aid, the aid of drugless practitioners and chiropodists;
- hospital and special nursing services may be paid for;
- the worker is entitled to artificial members, apparatus, dental appliances and apparatus, including repairs or replacement in some circumstances;
- legitimate medical air expenses include travel costs, maintenance costs, clothing allowances, attendant's allowance; purchase of prosthetics, braces, wheelchairs etc. are covered;
- some employers are required to provide first aid or emergency equipment at the workplace, and an ambulance or transportation to doctor, hospital, or home immediately after an accident;
- the program is rehabilitation oriented; Ontario Workmen's Compensation Board operates a rehabilitation hospital and centre;
- it is unlawful for an employer to collect or retain any contribution toward medical aid; and
- doctors are not entitled to collect from the worker for services under the Workmen's Compensation Act.

Compensation to which a worker is entitled under the Workmen's Compensation Act is a right, and takes the place of the worker's right of legal action arising from an accident. Thus the worker may not sue the employer or generally speaking any other employer or covered workers for damages for injuries received in the course of employment. If, however, a non-covered third-party is liable, the worker has the choice of taking action against the third-party or of claiming workers' compensation benefits. The employee who claims workers' compensation subrogates the rights of legal action to the Board.

Victims of Automobile Accidents

Third-party liability coverage and accident benefit coverage is compulsory for every person who owns a licensed automobile in Ontario. In general, victims of automobile accidents are covered for all costs of medical care and rehabilitation. In addition to the basic OHIP medical care, victims are entitled to all of the supplementary benefits included in extended health care plans. Further any rehabilitation costs, both training and facilities, would normally be covered.

OHIP has the right of subrogation against insurers for the costs of any insured services provided to victims of automobile accidents.

Eligible War Veterans

Federal government policy is that entitled Canadian veterans will receive the best quality of medical care and treatment. Eligibility for veteran's benefits exists where a disability, or aggravation of a pre-service disability, is attributable to specified military and sometimes civilian service.

Sick and disabled veterans may be provided with:

- hospital care in veterans' hospitals or in veterans' sections of community hospitals;
- medical and dental treatment;
- prosthetic services; and
- special allowances for exceptional incapacity, special clothing, an attendant, etc.

Victims of Criminal Injuries

The government of Ontario has recognized the need for assistance to the victims of crimes of violence, and has established the Criminal Injuries Compensation Board to look after this need. This Board is authorized to award compensation to victims of crimes of violence, committed within the Province, and which result in personal injuries or death. The crime must be one which is an offence under the criminal code of Canada.

Persons eligible for compensation include:

- the innocent victim;
- the person responsible for the cost of providing for the victim;
- where the victim dies, any dependant of the victim;
- where the victim dies, any person who incurs expenses on behalf of the victim or his estate as the result of the victim's injury or death; and
- the person responsible for the maintenance or support of a child born as a result of rape.

Coverage is applicable to residents and to non-residents. It applies to police and correctional officers. Compensation for eligible victims includes actual and reasonable expenses paid out as a result of an injury for medical bills, prescription drugs, dentures or eyeglasses.

F. SOCIAL ASSISTANCE

Persons and families who are unable to support themselves for whatever reason may be eligible for social assistance from various levels of government. In the short term, social assistance includes General Welfare Assistance from the municipality. Long term benefits come from the Province under the Family Benefits Act. Eligibility depends on assets and amounts of income from other sources.

The medical care provisions include:

- Persons and families who are recipients of Ontario Family Benefits receive free OHIP coverage, prescription drugs, eyeglasses, and basic dental care.

- Those receiving family benefits who live in a home for the aged, a charitable institution, or a nursing home receive an amount toward the cost of care, plus an amount per month as personal spending money.
- General Welfare Assistance provides OHIP coverage and may include allowances for dental and optical services, artificial limbs, hearing aids and transportation to doctors, when authorized by the welfare administrator.

G. MISCELLANEOUS GOVERNMENT PROGRAMS IN ONTARIO

Some other government programs and services involving medical care available in Ontario are listed below:

- The University of Waterloo has a Low-Vision Clinic.
- Visiting Nurses provide in-home medical care for the handicapped, convalescent, chronically ill, elderly and other disabled persons remaining in their own homes.
- Public Health Nurses provide service in many areas including low income housing, senior citizens' apartments, and private home counselling.
- The Province licences and funds Children's Mental Health Centres, and provides nursing and medical care, and treatment programs for the developmentally handicapped.
- Grants are provided to schools for personalized special education equipment such as wheelchairs, hearing and vision devices.
- The Province shares the cost of 16 Crippled Children's Treatment Centres, which provide speech therapy and physiotherapy.
- General and Special Rehabilitation Hospitals, and Special Rehabilitation Units of Public and Regional Hospitals offer co-ordinated programs of rehabilitation and physical medicine to persons recovering from injuries, disabilities or acute stages of illness.
- Adult Rehabilitation Centres provide co-ordinated programs on an out-patient basis to assist persons with severe disabilities who no longer require in-patient care.
- A monthly allowance is available for drugs, dental care, and assistive devices for eligible families caring for a severely handicapped child at home.
- Free Prescription Drugs from the Ontario Drug Formulary are available to those eligible for the Ontario Drug Benefit, including senior citizens, residents of Extended Care facilities, residents of Homes for Special Care, and Home Care recipients. In addition, some pharmacies offer reduced prices on non-prescription items.

- Nursing Homes and Homes for Special Care provide extended care services for those who need at least 1½ hours of nursing care a day.
- St. John Ambulance offers home nursing courses, and has developed a special program (Health Care for Seniors), which covers first aid, home nursing, nutrition, accident prevention, use and misuse of drugs, and ageing.

H. TAX RELIEF FOR MEDICAL CARE COSTS

As indicated above, there are a variety of health care costs that people must meet from their own resources. Some of these expenses are partially offset through various tax relief programs. The sick and disabled may benefit from any or all of the following:

- Taxpayers are eligible for a deduction from taxable income for medical expenses. For income deduction purposes, medical expenses are grouped with charitable donations, and one or other of the following may be used:
 - a standard deduction of \$100, or
 - the sum of qualifying medical expenses exceeding 3% of net income, plus actual charitable donations.
- In addition, some other deductions are available to reduce income tax of disabled taxpayers, or of taxpayers with disabled dependants.
- Provincial sales tax does not apply to:
 - prescriptions,
 - artificial limbs and prosthetic appliances,
 - orthopaedic appliances,
 - equipment designed solely for the use of the blind, crippled, or chronic invalids, and
 - hearing aids.
- A provincial sales tax rebate is available for motor vehicles adapted for operation by a person with a physical handicap; or the transportation of persons who have a permanent physical handicap which renders it impractical for them to use usual public transportation.

CHAPTER 3

Dental Care Coverage

A. INTRODUCTION

People may require dental treatment and care as the result of accident and injury. In addition, dental care involves good oral hygiene and both preventive and maintenance dentistry. Dental care differs from medical care, as there may be greater opportunity for individuals to avoid treatment by exercising effective preventive care.

There is no comprehensive public dental care protection plan in Ontario as there is for medical care. OHIP covers only specific dental services in hospital. Residents of Ontario must therefore rely more extensively on their own resources or other sources of financial protection to defer the costs of dental care.

In this chapter the coverage provided by OHIP is reviewed briefly followed by a recapitulation of some of the aspects of other plans and programs available.

B. DENTAL CARE THROUGH OHIP

OHIP coverage of dental care is restricted to dental care in an Ontario hospital and provides for the payment of dentists' fees, for a specified list of procedures, based on an OHIP approved schedule of fees arrived at after discussion with the Ontario Dental Association, when:

- provided for an in-patient; and
- performed in an approved hospital; and
- performed by a dental surgeon who is a member of the hospital's staff.

Hospital charges for the above services are also covered.

For dental services performed out-of-province, the plan provides coverage for the same amount it would pay if the services were performed in Ontario.

The insured is responsible for payment of any difference between the bill and the amount allowed by the plan.

C. PREPAID DENTAL PLANS

Unlike extended health care which is available to eligible subscribers on a group and an individual basis, dental care plans are only available on a group basis. In the latter part of 1980, Blue Cross began offering on an experimental basis dental care plans to individuals in two counties in the Province. The plan was unsuccessful since a premium structure could not be designed that would

attract participants and at the same time ensure the financial viability of the plan to Blue Cross.

The available dental care plans are described in some detail in Part II of this Report. Essentially the types of coverage offered are:

- basic dentistry, which includes preventive and maintenance activities;
- major restorative procedures, which includes crowns, bridges, dentures, and appliances; and
- orthodontic services, which include teeth straightening, braces, etc.

D. SPECIAL DENTAL CARE COVERAGES

Workers eligible for workers' compensation and injured on the job have coverage for dental aid, and for dental appliances and apparatus. Likewise victims of automobile accidents requiring dental care are covered for all of their costs under the accident benefit provisions of Ontario's compulsory automobile insurance legislation.

Eligible victims of crime receive compensation for dental expenses, including dentures; provided that the benefits do not duplicate other coverage.

E. UNION DENTAL CARE PLANS

Some unions have arranged dental care plans for their members and families. Three types of such plans are:

- eligible members and families have their needs served at a specific clinic;
- a dentist agrees to provide specific dental services to subscribers and their families for a fixed monthly fee.
- eligible members and families have their dental services provided for them by a dentist of their choice.

F. PERSONS RECEIVING SOCIAL ASSISTANCE

Persons and families on Family Benefits receive basic dental care. General Welfare Assistance includes allowances for dental services, when authorized by the welfare administrator.

CHAPTER 4

Provision of Income Protection During Periods of Sickness and Disability

A. INTRODUCTION

In this chapter attention is directed to the sources presently available to residents of Ontario for income maintenance during periods of sickness or disability and disability compensation. It does not cover various government programs that are available to all qualifying residents, regardless of their health, accident, or disability situation. Therefore, it does not include reference to such government programs or features of particular programs as: Family Allowances; Child Tax Credits; Unemployment Insurance Commission one time benefit at age 65; Old Age Security; and the Ontario Property, Sales, and Pension Tax Credits. It also excludes peripheral programs such as manpower training allowances.

As has been suggested, there is a vast array of both private and public programs in place in Ontario all designed to address specific aspects of the concerns of particular segments of the population for income protection during periods of sickness and disability. That the system has a modicum of success is evidenced by the fact that very few in Ontario are completely destitute as a result of sickness or disability.

Many sick and disabled have access to income protection because of employment. Some, both earners and non-earners have resorted to various insurance plans for protection. Some disabled may receive compensation related to the cause of their disabilities, such as, disabled veterans and victims of motor vehicle accidents. Others may be dependent on social assistance.

A listing of source of income maintenance and disability compensation in Ontario would include:

Short-term programs for employees:

- Voluntary payments by employers
- Employer/employee jointly administered sick leave and weekly indemnity plans
- Disability benefits from unemployment insurance
- Weekly indemnity plans—insured

Long-term programs for employees:

- Workers' compensation
- Disability benefits under Canada Pension Plan
- Disability benefits under other pension plans
- Long-Term income continuance plans—insured
- Group life insurance disability provisions

Programs for individuals—insured

Other sickness and accident plans—insured

Other sources:

- Personal resources
- Successful court action
- Veterans' disability pensions
- No-Fault automobile accident benefits
- Compensation for criminal injuries
- Social assistance
- Miscellaneous government programs in Ontario

The overview in this chapter of these programs and plans provides a perspective of the "system" by considering segments of the population in keeping with the foregoing listing by reviewing short-term programs for employees; long-term programs for employees; insured programs for individuals; and, other sources available to individuals in certain circumstances. In each case an effort has been made to indicate the main features of each program by considering if practicable, a number of matters concerning each:

- availability;
- eligibility;
- waiting period;
- level of benefits;
- duration of benefits;
- contributions; and
- tax status.

B. SHORT-TERM PROGRAMS FOR EMPLOYEES

Voluntary Payments by Employers

Many employers have programs of salary or wage continuation for employees during periods of sickness or recovery from an accident. There is usually no waiting period under such plans and benefits are usually paid at the full salary or standard wage level. The payments may continue for varying periods of time depending upon the philosophy of the individual employer concerned. The benefits are taxable.

As these plans are generally informal, there are no criteria on which to assess either the availability or eligibility for benefits. There are instances when eligibility for voluntary payments is limited to white collar workers and when other employees are required to rely on their own resources during short periods of sickness or disability.

Employer/Employee Jointly Administered Sick Leave and Weekly Indemnity Plans

Some employers, notably governments but others also, have formalized

sick leave and weekly indemnity plans with their employees. Such employer/employee plans are frequently administered jointly by employee representatives and the employer.

It is usual under such plans that it is available to all full-time employees after a short probationary period. Part time and temporary employees are often excluded. Once eligible an employee usually may take sick leave at full pay for a certain number of days with the total number of days dependent normally on years of service and sick time accumulated and used. The maximum period of benefits under such plans may be as long as six months. Sick leave pay is taxable as normal income from employment.

Disability Benefits from Unemployment Insurance

Under the provisions of the Unemployment Insurance Act benefits are provided not only to those unable to find work but also to those absent from work due to sickness, non-occupational accident or pregnancy.

Benefits under the Unemployment Insurance Act are available to most Ontario employees under age 65. Excluded are the self-employed, those employed by a spouse or a supporting relative, casual workers, and those employed by a provincial or foreign government, although a provincial government may waive the exemption and agree to have its employees insured.

Contributions are made to the Unemployment Insurance Fund by both employers and employees. Employee premiums in 1980 were 1.5% of weekly earnings to a maximum of \$3.92 per week with employers contributing \$1.40 for each \$1.00 of employee contribution. Contributions are not required by or for employees working less than 20 hours in any one week. In order to be eligible for benefits an employee must have contributed for at least 20 weeks in the last 52 weeks.

Benefits are payable at 60% of average insurable earnings to a maximum, in 1980 of \$754 per month. Benefits are payable for up to 15 weeks, commencing two weeks from the Sunday prior to the day for which benefits were first claimed. All benefits are taxable.

Unemployment sickness benefit payments will be reduced in any week that benefits are paid from any sick pay, weekly indemnity or any other employer-related private sickness plan or under the Manpower Training Program. A workers' compensation claimant may not receive unemployment insurance sickness benefits.

The Unemployment Insurance Fund is the "second payor" of sickness benefits since any payments from a weekly indemnity or sick pay plan may be deducted from the amount that it might otherwise be required to pay. In recognition of this fact the rate of contributions to the fund may be reduced

where an approved sickness plan is registered with the Unemployment Insurance Commission. An approved plan must provide benefits at least equal to those payable under the Act. However, an approved plan need not apply to all employees. It may, for example, be limited to employees of a particular bargaining unit or to salaried employees so long as at least 95% of the employees in the specified group are covered by the plan. Employees covered by an approved plan would not normally claim unemployment insurance for as long as the approved plan pays. Thereafter provided they qualify they may claim unemployment benefits.

Since disability and out-of-work benefits are provided from the same plan, a period of claims for unemployment benefits may reduce or eliminate the sickness benefit coverage and vice versa.

Weekly Indemnity Plans—Insured

Many employers in Ontario have arranged short-term weekly indemnity plans through insurance companies. These plans may have been either the result of collective bargaining with employees or employer initiated to replace voluntary payments and to supplement government programs.

Because there is no compulsion on the part of employers to institute these plans, benefits are only available to employees of organizations with such plans. The cost of the plan is usually shared by employees and the employer, although some plans are supported entirely by employer contributions.

Eligibility for benefits varies depending on the terms of each contract but plans are usually designed to provide benefits to all full time employees after a probationary period. Frequently, in order to be eligible an employee must be actively-at-work at the time the plan is introduced or coverage is deferred until he or she returns to full-time employment.

Benefits usually begin from the first day for accidents and either the fourth or eighth day for sickness. Benefit payments continue for periods that usually range from 15 to 26 weeks although some plans extend benefit periods for as long as 52 weeks. Benefits are sometimes a flat amount per week although other plans stipulate a percentage of standard weekly salary or wage. Benefits are taxable to the employee if any portion of the cost of the plan was borne by the employer.

Weekly indemnity plans usually cover only absences arising from non-occupational accident or illness. As noted in the discussion preceding on unemployment insurance sickness benefits, absence from work due to disability or pregnancy are also covered under the Unemployment Insurance Act. Unemployment insurance disability benefits are reduced by amounts paid under a private plan, however if an insured weekly indemnity plan meets certain conditions it may be registered with the Commission and the unemployment insurance premiums will be reduced.

More detailed discussion concerning all sickness and accident income protection plans offered by insurance companies follows in Part II of this Report.

C. LONG-TERM PROGRAMS FOR EMPLOYEES

Workers' Compensation

The activities of the Workmen's Compensation Board include not only the provision of medical care and income protection to workers injured on the job, but also the development and implementation of programs of safety, accident prevention, industrial hygiene, first aid, and rehabilitation. Some comments concerning workers' compensation and in particular its medical care provisions were set out in Chapter 2. In general, all employees working in specified industrial operations are covered. No employee contributions to the program are required. Employers' contributions vary by industry. Compensation is payable where there is personal injury by accident arising out of and in the course of covered employment, and in the case of industrial diseases as defined by the Act. There are two exceptions:

- where the injury does not disable the employee beyond the date of the accident from earning full wages for the work at which he or she was employed;
- where the accident is attributable solely to the serious and wilful misconduct of the employee and does not result in death or serious disablement.

Negligence on the part of either the employer or the employee does not affect compensation.

An employee must report any accidental injury to his or her employer and to the Workmen's Compensation Board. The employer must also report the injury and, where the injury involves lost time beyond the day of the injury, the treating doctor must also report. If a worker cannot return to work because of an injury, he or she will usually be regarded as temporarily totally disabled. In due course the worker will be assessed as either:

- fit to return to work, or
- able to return to work but with a temporary partial disability, or
- able to return to work but with a permanent partial disability, or
- permanently totally disabled.

Benefits will be set according to this assessment.

Compensation available in non-fatal cases is as follows:

- Eligible workers receive compensation, subject to a maximum, for lost earnings and/or pensions for full or partial permanent disability, offset against any wages paid by the employer during the period.

Where the employer pays wages, the workers' compensation payments for the same period are paid to the employer by the Board.

- Weekly payments are presently set at 75% of earnings for total disability with a maximum covered earnings in 1980 of \$18,500 per annum. Maximum weekly benefits in 1980 were therefore \$266.83 or \$13,875 per annum.
- An injured worker in 1980 is entitled to compensation of not less than \$129 weekly, where average earnings are between \$129 and \$172, or the amount of average earnings for average earnings less than \$129 per week.
- Permanent disability pensions are based on the degree of disability and are paid for life.
- Where a partially disabled worker returns to work, workers' compensation pays 75% of the loss of earnings, subject to a maximum.
- Where a permanent disability is rated at 10% or less impairment, compensation may be paid in a lump-sum.
- Workers considered eligible for a Canada Pension Plan (CPP) disability pension, i.e. not capable of working, may not be eligible for workers' compensation supplement which may be paid to those available for employment.

Compensation available in fatal cases was as follows in 1980:

- Spouse receives a lump-sum of \$1,000.
- Transportation and burial expenses are covered to a maximum of \$1,000.
- Spouse receives a monthly pension of \$410 and a lump-sum of 2 years pension on remarriage.
- Each child receives a monthly pension of \$112 until age 16 regardless of whether or not the surviving parent remarries; and beyond for educational or invalid reasons. Orphans receive a higher pension of \$127 per month.
- Other dependants receive a pension, maximum of \$410 per month, if there is no spouse or children.
- Foster parents of orphaned children may receive the same pension as a spouse.
- Death benefits to dependants of permanently disabled employees are paid regardless of the cause of death.

The enabling legislation permits the periodic raising of the minimum and maximum compensation levels.

An appeal process is available against decisions of the Board concerning levels of disability as well as other matters that may be in dispute.

Workers' compensation benefits are non-taxable.

In addition to provisions regarding medical care and compensation, the other most important service of the Workmen's Compensation Board concerns rehabilitation of injured workers. The Vocational Rehabilitation Department of the Board operates rehabilitation offices offering rehabilitation services which include:

- vocational and social counselling;
- selective job placement counselling;
- vocational appraisal;
- trade and skills training; and
- vocational training.

There is no financial or time limit on either physical or vocational rehabilitation services. Rehabilitation and the Board's rehabilitation programs are discussed in more detail in Part III.

Disability Benefits under the Canada Pension Plan

Disability benefits are payable under the Canada Pension Plan (CPP). To be eligible for benefits under this plan, recipients must have made CPP or Quebec Pension Plan contributions for a minimum of five of the last 10 years in which they could have done so up to the time of the disability.

The definition of disability for purposes of the Act is restrictive—

“A person shall be considered to be disabled only if he is determined in a prescribed manner to be suffering from a severe and prolonged mental or physical disability, and for this purpose,

- (a) a disability is severe only if by reason thereof the person in respect of whom the determination is made is incapable regularly of pursuing any substantially gainful occupation, and
- (b) a disability is prolonged only if it is determined in prescribed manner that such disability is likely to be long continued and of indefinite duration or is likely to result in death.”

In determining disability, CPP considers medical reports on the physical or mental impairment from the treating doctor and hospital, if any. The medical evidence is examined by CPP's own doctors and additional advice is sought if needed.

If a person is judged as having a prospect of recovery or return to work, then he or she is not eligible for disability benefits under the CPP. In considering whether there is any possibility of re-employment, CPP takes into account: past or usual employment, any other occupation the applicant could hold, age, education, experience and physical or intellectual limitations.

Benefits for eligible applicants start in the fourth month after the month in which the disability begins and continue until recovery, age 65, or death.

At age 65, the disability pension is replaced by the normal retirement benefit plus the Old Age Security benefit applicable.

Employees who qualify for disability pension from the CPP received in 1980 a flat rate of \$57.25 a month, plus 75% of the employee's retirement pension at age 65 up to a monthly maximum in that year of \$240.58 per month. Additional benefits are paid for persons with dependant children. Pensions are indexed annually. Employees and employers contribute equally to CPP at 1.8% of employment earnings to a maximum dollar amount. The self-employed contribute 3.6% to a maximum dollar amount. Benefits are taxable but contributions are deductible in determining taxable income.

Disability pensions are re-assessed periodically, and a small proportion are found to be no longer disabled within the terms of the Act. Others may recover and return to work and inform the CPP. To counteract any disincentive to return to work, the disabled person may be allowed a work trial period during which the pension is continued. If the pension is stopped and the individual suffers a relapse within a few months, the pension may be re-instated on application without a waiting period; it may even be back-dated.

There are appeal procedures for disputed decisions involving such matters as the definition of substantial or regular gainful employment, the problems of the disabled self-employed who try to keep a business going with family help, and the variations in decisions regarding disability by different pension granting authorities.

Disability Benefits under Other Pension Plans

Some retirement pension plans include provision for a disability pension or early retirement pension. This is common in public sector pension plans. Eligibility for benefits may be dependent on factors such as minimum age and/or years of service. Persons who change employment may lose coverage because of the lack of portability between pension plans.

There are no standard features to plans which provide disability or early retirement pensions. Usually, however the total amount of the benefit is determined as the amount of the regular pension accruing at the date of disability or early retirement reduced by calculations to reflect mortality and interest factors and the applicant's age. A few pension plans are designed to reflect in the calculation of the total amount of disability benefits payable both past and prospective service, i.e. a pension equal to what the employee would have received if he had remained in service until normal retirement age at his last salary.

Most plans pay benefits at a flat amount per month that continue until death. In some cases, on the death of the insured, the pension or a part pension continues for the spouse of the insured.

Disability pension benefits are taxable.

The definitions of disability under an insured plan are usually restrictive. Where a long-term income continuance plan is also in effect in an organization, any disability benefits under its pension plan are normally modified to provide a deferred annuity at retirement age.

Long-Term Income Continuance Plan—Insured

As in the case of weekly indemnity, short-term plans, many Ontario employers have arranged long-term income continuance plans for their employees through insurance companies.

Details concerning a number of matters about these plans are set out in Part II of this Report. However, in general, these features may be summarized as follows:

- Since there is no obligation for employers to institute such plans, they are only available to employees of organizations which have instituted programs of this type either of their own volition or as the result of collective bargaining with their employees.
- All full-time employers are normally eligible for benefits immediately the plan comes into force. However, most plans limit eligibility to employees “actively-at-work” when the plan is introduced, with coverage for those absent from work commencing when they return to full-time employment.
- Most plans exclude new employees until a probationary period has been worked. Temporary and part-time employees are also normally excluded.
- Long-term income continuance plans are usually designed to mesh with other public and private income maintenance plans for employees during periods of sickness or disability. Therefore, there is normally a waiting period before benefits are paid under these plans to coincide with the cessation or reduction of benefits under other plans.
- Typically benefits are payable until recovery, to age 65 or for life at levels designed to provide an income to insureds at a stipulated percentage of pre-disability earnings. In calculating the benefits payable under an income continuance plan benefits received by insureds from workers’ compensation, CPP, third-party automobile insurance, crime compensation or private disability pensions would be taken into account.

Contributions to this type of plan are usually made by both employees and employers. Frequently employers pay a larger share of the total contributions than employees and in some instances pay the total amount.

- Benefits are taxable if the employer pays any part of the premium for the plan.

Group Life Insurance Disability Provisions

Group life insurance is a fringe benefit available to some employees. Some group life insurance contracts contain a disability instalment provision. This subject was discussed on pages 188-9 of the Committee's Fourth Report and a portion of that discussion is worth repeating in the context of the present review.

“The disability instalment provision, although it is not offered in all group contracts, is available for an extra premium. It provides that in case an employee is totally and permanently disabled, the amount of insurance benefits under the policy will be paid in regular instalments over a period of years, usually 5. This provides the disabled person with the benefit of income payments out of his group life policy. The instalment payments however reduce the amount of insurance in force and at the end of the payment period, the life insurance contract is terminated. Termination of coverage through payment of the sum insured may provide needed disability benefits to the disabled employee but it results in loss of life insurance coverage at a time when ordinary life insurance may be difficult to obtain.

The terms of the disability instalment provision in effect alter the life insurance contract to a contract of disability benefits. In some cases, the disabled employee may not regard this disposition of his life insurance coverage to be most appropriate to his circumstances but no other options are made available to him with this provision in force.

The definition of disability in these policies is usually very restrictive. Payments of benefits commence after proof of disability satisfactory to the insurer has been processed. Disability benefits under group life policies are not taxable as they are considered prepaid death benefits.

D. PROGRAMS FOR INDIVIDUALS—INSURED

The discussion in the previous two sections has dealt with income protection plans that are or may be available to employees during periods of sickness or disability. In addition, these employees, other earners, the self-employed and in some instances non-earners are able to take advantage of sickness and disability income protection plans provided by insurance companies.

The details of these other plans and including matters relating to underwriting and pricing practices, marketing and claims handling are dealt with in Part II of this Report. A brief summary of the more significant features of these programs only is set out here under a number of general headings.

Availability

Marketing sickness and disability income protection plans to individuals has always been difficult for insurers. It is an area where the insurance companies readily admit that they have not been very successful. The major innovative approach insurers have used is to reach individuals through an “association group” concept. With this approach individuals belonging to professional or common interest groups are sold policies using rating, pricing and marketing techniques that are similar to those used for employer/employee groups.

Eligibility

In determining eligibility for individual sickness and disability income protection plans insurers apply very tight underwriting procedures before contracts are issued. Further, the definitions of disability entitling an insured to benefits are normally very restrictive.

Waiting Period

While there can be wide variation among contracts, usually individual sickness and disability income protection plans have longer waiting periods before benefits commence than is the case for employer/employee group plans.

Level and Duration of Benefits

Since a contract of this type must meet an individual applicant’s particular needs, insurers are generally very flexible in this aspect of the plans they are prepared to provide.

Tax Status

Benefits are non-taxable if fully funded by the individual and taxable if funded by an individual’s business.

Offset and Integration

When insurers design individual sickness and disability income protection plans they generally attempt to take into account other similar sources, public and private, of income protection available to the applicant. However, frequently this presents problems and situations of over-insurance by individuals is common. Many people do not know they are over-insured. It is only when claims are submitted and a portion of their premiums are returned instead of the benefits they may have been expecting that they become aware that they have been duplicating coverage.

E. OTHER ACCIDENT AND SICKNESS PLANS—INSURED

As has been noted, insurers are not satisfied with their ability to provide individual income protection to individuals during periods of sickness and disability. This is not to say that attempts have not been made to respond to certain perceived consumer needs. Indeed there is a multiplicity of plans designed to make coverage available to selected segments of the population.

It is impractical to generalize concerning the various criteria such as eligibility, waiting periods, level and duration of benefits, and the problems of integration of these plans. There is only one aspect of commonality—benefits are non-taxable if the premiums are paid by an individual.

A partial list of these “other” types of plans is set out below, further reference to these plans and more details concerning some of them is made in Part II.

- business interruption insurance,
- accidental death and dismemberment,
- homeowner’s disability policy,
- cancer insurance,
- travel insurance,
- blanket insurance for students, campers, etc.,
- creditor’s insurance,
- car rental death and dismemberment insurance.

F. OTHER SOURCES OF FINANCIAL PROTECTION DURING DISABILITY

In addition to the income protection provisions and disability compensation coverages available to the employed and individuals, described in preceding sections of this chapter, there are other sources of financial protection to which Ontarians may resort depending upon their particular circumstances.

Personal Resources

Those persons who do not have other forms of income protection at times of disability through their place of employment, or any public plan and who either by choice or ignorance have not availed themselves of insured accident and sickness plans must rely initially on their personal resources to defray the costs which continue during periods of incapacity. The only alternative for many in this situation is social assistance which may be provided after satisfying a needs test.

Successful Court Action

In some instances a civil action may be undertaken against a third party to obtain income maintenance or an award if the third party is judged

negligent and causing an accident or illness. Considerations in this regard include:

- persons who have suffered bodily injuries or their survivors might bring action against designers, producers, or sellers of hazardous products; or against a person or business for hazardous premises;
- successful suit may result in settlement out-of-court, or a court judgment;
- an award might include provision of a lump-sum and/or a pension for the injured party or for the survivors;
- some individuals and businesses will carry liability insurance to meet the costs of such awards; others will self-insure; and
- such awards are normally non-taxable.

Veterans' Disability Pensions

Veterans' disability pensions provide compensation and medical care coverage. A veterans' disability pension is compensation for injury suffered while in service, not an income replacement scheme. Accordingly, the pension is not affected by employment, other pensions, or assets although some other disability income programs may deduct the amount of veterans' pensions. Eligibility for veterans' benefits exists where a disability, or aggravation of a pre-service disability, is attributable to military service. Coverage is as follows:

- eligible veterans receive \$811.46 a month (1980) for 100% disability;
- the size of the pension is based on an assessment of the percent of disability;
- higher pensions are paid for married couples and for married couples with two dependants;
- pensions are indexed to the consumer price index; and
- veterans' disability pensions are not taxable.

No-Fault Automobile Accident Benefits

Ontario's compulsory no-fault automobile accident benefits provide income protection for those injured in automobile accidents under certain circumstances.

In order to be eligible a person must be actively engaged in an occupation or employment for wages or profit at the time of the accident or must have been employed for at least 6 of the 12 months preceding the accident and disability must occur within 30 days of the accident.

Benefits are paid from the date of the accident or date of disability at 80% of gross income from employment to a maximum in 1980 of \$607 a month.

After the first two weeks, benefits are integrated with other public and employment plans. Benefits which are non-taxable may continue for 104 weeks for eligible residents unable to perform “any and every duty pertaining to his occupation and employment”. After 104 weeks a permanent disability must be approved.

Compensation for Criminal Injuries

Compensation for criminal injuries provides for both medical care and for income protection. Eligibility for benefits was described in Chapter 2. Compensation coverage is as follows:

- an award to an eligible victim may include compensation for net salary or wages lost, pain and suffering, maintenance of a child born as a result of rape, other monetary loss resulting from the injury, or any other expense that the Board views as reasonable;
- an award may be in the form of a lump-sum, and/or a pension for a period or for life;
- a death benefit may include provision of a lump-sum and/or a pension for a period or for life;
- to December 1980, awards have ranged between \$150 and \$32,000, and up to \$500 per month;
- funeral expenses may be covered;
- monetary losses incurred by dependants may be covered;
- an award will not duplicate benefits received by the applicant from other sources such as an insurance plan, OHIP, workers’ compensation, UIC, welfare, and CPP; and
- awards are non-taxable.

Social Assistance

In the short term, social assistance includes General Welfare Assistance from the municipality. Long term benefits come from the Province under the Family Benefits Act, and provide medical care coverage and financial assistance. Medical care coverage and eligibility considerations were discussed in Chapter 2. The financial provisions include:

- short-term financial assistance is available to qualifying persons and families as weekly or monthly General Welfare Assistance allowances.
- Family Benefit long-term allowances are available to qualifying persons and families, including blind and disabled persons.
- qualifying blind and disabled persons receive a supplement, the Guaranteed Annual Income Supplement (GAINS (D)).
- allowances are reduced for any amounts received from UIC, work-

ers' compensation, CPP, veterans' pension, private disability pension, group insurance income replacement, and income from no-fault motor insurance, or from criminal injuries compensation.

- lump-sum payments from such sources are offset against benefits for that month; receipt of the lump-sum might also preclude eligibility because of the resulting assets.
- under the Work Incentive Program (WIN), disabled persons who wish to be self-supporting received cash benefits in 1980 of up to \$185 per month, when income was below \$593 per month, and reduced cash benefits, for income within a range above the specified amount, for up to two years of full time employment. An allowance of \$225 was provided for back-to-work expenses; and family medical coverage continues while the person is involved in the program; this program may be of use where work is possible and obtainable by a disabled person.
- social assistance payments are not taxable.

Miscellaneous Government Programs in Ontario

Miscellaneous Government programs and services, involving income or expense elimination for the sick and disabled in Ontario, are outlined below:

- the Province has established the Handicapped Employment Program to increase private sector employment opportunities;
- the Human Rights Code is under review regarding coverage of the physically disabled and their access to employment opportunities among other matters;
- procedures are being reviewed for the issuance of permits for less than minimum wage employment of retarded and handicapped persons;
- home support services are provided to disabled adults in 209 housing units; most costs of personal care, housekeeping, meal preparation with the exception of food, and laundry services are covered; rent is on a geared-to-income formula;
- the Province provides subsidies to municipalities for the operation of special transportation services at regular transit fares for the physically disabled, and for the provision of features such as grab rails, ramps, and benches for conventional transit;
- the Province provides grants for the construction or renovation of ramps, elevators, etc. for handicapped persons in wheelchairs at community recreation centres;
- the Province provides consultation on the development of leisure services for disabled people.
- two percent of new senior citizen housing planned and built by the

Province is designed specifically for wheelchair dependant individuals; existing units are modified, including widening doorways, installing grab rails, redesigning cupboards, etc.;

- the Province provides counselling, psychological testing, specialized assessment and training services, restoration and job placement services for physically, mentally or emotionally disabled persons who are vocationally handicapped; the goal is to develop, restore or improve the working capacity of the individual to enable them to obtain employment; this includes employment in the open labour market, in-home or sheltered employment, or self-employment;
- simulated working conditions are available to disabled persons in workshops operated by voluntary organizations and subsidized by the Province; and
- grants are available to six voluntary organizations providing rehabilitation services to disability groups with highly specialized needs; included in these groups are persons with hearing or sight impairment, those who are mentally retarded, and those with spinal cord injuries.

PART II

THE ROLE OF THE INSURANCE INDUSTRY AND THE
NON-PROFIT PREPAID MEDICAL CARE ORGANIZATIONS
IN THE DISABILITY FINANCIAL PROTECTION SYSTEM

CHAPTER 5

Types of Insurance Coverages Available to Residents of Ontario

A. INTRODUCTION

Accident and sickness insurance companies and non-profit prepaid medical care organizations provide residents of Ontario with a wide variety of products designed to respond to their financial protection needs at times of sickness and disability. Products include medical care and dental care plans, short-term and long-term disability income protection plans and the provision of lump-sums on accidental death and dismemberment. The products offered are designed to complement benefits of a similar nature that form part of government social security programs.

This chapter deals with the products offered by accident and sickness insurance companies and those products offered by non-profit prepaid medical care organizations licensed under The Prepaid Hospital and Medical Services Act under the following headings:

- medical care plans,
- dental care plans,
- plans for income protection during periods of sickness or disability, and
- other accident and sickness insurance plans.

B. MEDICAL CARE PLANS

Private medical care plans must be considered against the background of the government plan. As government has effectively pre-empted the basic hospital and medical care field, as discussed in Part I, the private medical care plans are limited to covering only the services not covered by OHIP. Even with the provision of certain coverages by private medical care plans there are still medical care services which have not been insured against, these include:

- medical examinations or certificates required for applications for employment, life insurance or admission to camps or recreational activities,
- cosmetic surgery for the purpose of beautifying the body or improving the physical appearance where there is no health related effect; health related effects include physical health and mental or emotional health; the latter would be determined by the physician or psychiatrist treating the patient; cosmetic surgery includes procedures such as face-lifts, and changing the shape of a nose.
- acupuncture,

- health services not provided by approved hospitals or practitioners, and
- hospital visits solely for the administration of drugs.

In this section, the various medical care plans offered to residents of Ontario by private insurance companies and non-profit prepaid medical care organizations are described.

Extended Health Care Plans

Extended health care plans, where permitted by The Health Insurance Act, cover the cost of goods and services not covered by government programs but which may be required as part of treatment or care.

The goods and services which may be provided by insurance companies and by non-profit prepaid medical care organizations are:

- semi-private or private hospital room differentials;
- special duty nursing;
- local ambulance service;
- prosthetic appliances and durable medical equipment;
- wheelchair rental;
- in certain cases, practitioner services or costs beyond the limits specified in government plans;
- accommodation in emergency;
- services of a registered or licensed physiotherapist;
- services of a registered clinical psychologist;
- services of a registered masseur;
- blood and blood by-products;
- diagnostic services performed at a hospital; and
- dental care when necessitated by a direct blow to the mouth.

Extended health care plans may be offered on a group insurance basis or on an individual insurance basis. Group insurance is a contract of insurance providing coverage on the lives or well-being of a number of persons insured severally under a single contract between an insurer and a policyholder, most commonly an employer. Individual insurance contracts, on the other hand, are purchased by individuals to provide various coverages for themselves and their families and in some cases on the lives or well-being of other individuals in whom they have an insurable interest.

There are a number of different types of homogeneous groups including employee/employer groups, association groups, unions and creditor groups. As employee/employer groups are the most common the comments which follow are directed to this type of group, however, the same principles apply to other types of groups.

Employee/Employer Groups

The above noted coverages are available either in total or in part through negotiation to subscribing employee groups.

Extended health care coverage is available immediately to those employees actively employed on a full time basis. New employees are eligible to join after a probationary period set out by the employer. There are normally no other eligibility requirements.

For the group there are no waiting periods for benefits to start.

Occasionally smaller groups of employees must purchase group life insurance and accidental death and dismemberment insurance before an insurance company will make extended health care coverage available.

The plans usually pay for 100% of all eligible expenses, however some plans may stipulate lifetime maximums and others may have co-insurance clauses and/or deductibles.

Generally, coverage ceases on termination of employment except for a few plans where arrangements have been made for retirees to be covered until their death.

Under an employer/employee group plan the employer pays the premium to the insurance company or the non-profit prepaid medical care organization. Employees in many plans make contributions but the whole amount billed is remitted by the employer. The contributions made by the employees vary in amounts. Providers prefer and usually insist that employers pay the bulk of the premiums. Employer funding has several advantages to the provider:

- it makes group coverage more attractive to the employee and ensures the satisfactory enrolment required to make group coverage work at a cost lower than individual coverage;
- it protects the plan from getting just the unhealthy lives in the group as would be the case if healthier lives decided not to buy or decided to use their contributions to purchase coverage outside the group;
- it gives the employer a financial stake in the plan, ensuring his active interest in the operation of the plan and in its proper administration; and
- it ensures that fluctuations in the cost of the plan from year to year are absorbed by the employer without affecting employee participation.

Individual Subscribers

None of the insurance companies actively market extended health care plans to individuals. However, these plans are available from insurance companies in certain restricted situations, upon request. Historically, Blue

Cross has been the only non-profit prepaid medical care organizations licensed to carry on business in Ontario to offer extended health care plans to individual residents of Ontario who are not members of recognized groups. The Blue Cross plan is available to all individuals, for life, regardless of the level of risk which that person might present by virtue of age, pre-existing condition or medical history. The plan is open to new subscribers only for a few weeks each fall although subscribers to extended group health care coverage, upon leaving the group, may transfer to an individual pay-direct plan to maintain the continuity of their coverage. The Committee is pleased to note that, since the commencement of its hearings, Green Shield, another non-profit prepared medical care organization, has begun offering a plan to individual subscribers similar to that of Blue Cross.

Certain insurance companies offer extended care plans to individuals on a blanket insurance basis. These plans provide coverage for specific group activities to special risk groups such as athletes, students, campers, business travellers and attendees at conventions.

Prescription Drug Plans

Prescription drug plans are only offered on a group basis and generally a group must be 10 or more employees and at least 95% of the employees must be enrolled in the plan.

These plans provide coverage for all prescriptions written by a physician or dentist and dispensed by a pharmacist. There is usually a co-insurance clause or a co-pay clause, requiring that each time the insured purchases a prescription drug he must pay a nominal fee with the insurer paying the balance of the cost.

All benefits are available to employees and their dependants who are enrolled on the date the group becomes effective. There are no exclusions for chronic or pre-existing conditions.

Other Plans

Other medical care plans available are:

- vision care plans;
- hearing aid plans;
- nursing home plans;
- nursing care plans; and
- hospital money plans.

These plans are available on a group basis only, they are not marketed to individuals.

These plans are generally subject to varying amounts of deductibles and co-insurance provisions. There are no eligibility requirements, other than the group requirement, and no waiting period.

C. DENTAL CARE PLANS

There are a variety of types of dental care plans. The extent of coverage of a particular plan is spelled out in the plan contract. Essentially there are three basic types of coverage designed to help pay dental care costs. All plans cover aspects of prevention and maintenance dental care; in addition, some plans include restoration procedures, crowns, bridges, dentures and appliances; and the most comprehensive plans cover orthodontic services as well.

Dental plans are only available on a group basis and all regular full time employees in an employee/employer group are normally eligible although some contracts stipulate that an employee must have 6 months full time service before becoming eligible for benefits. Further, some plans do not cover certain pre-existing conditions. Blue Cross attempted to introduce a dental care plan for individuals on a limited basis during 1980. However, the experiment was unsuccessful since it was found impossible to establish a premium structure that would both attract subscribers and ensure the financial viability of the plan.

The level of benefits vary by plan. Normally, plans pay 80% of the Ontario Dental Association fee structure for all eligible expenses and there is usually a co-ordination of benefits clause with other plans to avoid the payment of greater than 100% of eligible expenses.

Benefits are payable to employees while they are employed. At termination of employment, most of the coverages under dental plans stop. Some plans make provision for benefits for expenses that are considered eligible if the dental care is received within 30 days following termination of employment and provided the benefits would have been payable had the insurance remained in effect.

D. INCOME PROTECTION DURING PERIODS OF SICKNESS OR DISABILITY

Sickness or disability income protection plans include plans offered by various government agencies and plans offered by private insurance companies. The non-profit prepaid medical care organizations do not offer coverages of this sort, since they would have to be licensed as life insurers under The Insurance Act as actuarial calculations regarding life contingencies are involved. In this section the plans designed to provide income protection during periods of disability offered by the private insurance companies licensed to transact business in Ontario are described. The various governmental plans were discussed in Part I.

Some of the plans offered by insurance companies are available to individuals, however, the majority of disability income protection plans are group coverages. They are reviewed briefly under the following headings:

- short-term disability income protection plans;
- long-term disability income protection plans;
- survivor income insurance; and
- rehabilitation benefit plans.

Short-term Income Protection Plans

Short-term disability income protection plans are available to groups and individuals. However, availability to the individual is limited. In the case of many employees, the gap is covered either by voluntary payments by employers or by sick leave credits, if any.

Employee/Employer Groups

Short-term sickness or disability income protection plans are available to all recognized groups. Eligibility for benefits varies among plans, in certain plans employees are covered from the date they start employment, in other plans new employees must have three or more months service before becoming eligible.

Group short-term sickness or disability income protection plans provide for benefits payable from the first day of a disability resulting from an accident and from the fourth or eighth day when sickness is the cause.

Levels of benefits also vary among plans but usually the level of benefit is based on length of service, with newer employees of less than one year service receiving benefits equal to say $66\frac{2}{3}\%$ of normal salary and long time employees of say ten or more years service receiving 100% of normal salary.

Plans offering benefits at least equal to the benefits offered by the Unemployment Insurance disability plan may be registered and replace the Unemployment Insurance plan. Otherwise private plans mesh with the Unemployment Insurance plans in various ways to provide benefits during periods of disability when none are paid by unemployment insurance.

Short-term plans do not duplicate the benefits of Workers' Compensation benefits.

The maximum period during which the sick or disabled person may receive benefits varies by contract with 30 weeks being the most usual upper limit.

If an employee uses up 30 weeks of benefits, re-qualification for 100% payments normally occurs after 13 continuous weeks at work.

In order for a plan member to qualify for benefits under the plan, the plan member must satisfy the employer that he or she is either sick or disabled. This is usually done with a physician's certificate.

Coverage under the plans terminate when the employee or group member ceases to be employed or otherwise ceases to be a member of the group.

Individuals

Income protection during sickness or disability is made available, by certain insurance companies, on an individual subscriber basis should the subscriber meet certain eligibility requirements.

Individuals wishing to purchase sickness or disability income protection plans must satisfy the insurer of his or her health status and the individual must fall within a certain occupational class to be eligible. These eligibility requirements are discussed in detail in Chapter 9. Certain individuals who may be routinely acceptable for individual life insurance contracts may not be acceptable for individual income protection during periods of sickness or disability.

The waiting period for benefit eligibility varies among plans with some plans requiring the individual to wait for a day in the case of disability, and 15 days in the case of sickness; and other plans stipulating a waiting period of 30 days.

The level of benefits also varies among plans. The benefit payable is usually some stipulated monthly amount based upon present income levels.

The duration of benefits is set out in the plan contract, for example, an insurance company may offer sickness benefits for a period of 6 months and disability benefits for a period of 12 months.

Certain insurance companies offer waiver of premium benefits which provides that in the case of the sickness or disability of the premium payer, premiums during the period of disability or sickness will be waived.

Long-term Income Protection Plans

Employee/Employer Groups

Long-term sickness or disability income protection plans are usually purchased in conjunction with short-term sickness or disability income protection plans so that benefits under the long-term plan begin immediately after short-term benefits run out, provided the sickness or disability continues. These plans are available to all recognized groups.

All full time employees actively-at-work are covered from the inception date of the plan. Certain other employees may have coverage from the date they commence employment or after a certain period of employment with a company.

Long-term sickness or disability plans usually provide benefits which

are integrated with other plans which an employer may have or with other benefits which the employee may receive from government plans in order to bring the employee's income up to a stipulated percentage of his or her salary or wages. The percentage varies among plans with the norm being 65% to 75% of take home pay. The insurance industry has indicated that benefits are kept at 65% to 75% of take home pay as their experience has proven that the incentive for claimants to return to work or complete a rehabilitation program is very much reduced if claimants are receiving total benefits close to or exceeding their pre-disability income. It is also felt that if the disability period is prolonged when a return to employment would be reasonable, many undesirable results can be anticipated. Any unnecessary delay in return to work has an adverse effect on the claimant. Prolonged absence from the work force creates a state of mind where it is difficult emotionally for the claimant to accept the regime and inconveniences of the usual work situation. Furthermore, an employer is increasingly less likely to offer employment in proportion to the length of absence from the work force.

It has also been stated that any unnecessary extension of the period of payment of disability benefits will obviously increase the claim costs of the insurance company involved. This will be reflected in the experience statistics on which premiums are based and will eventually result in all insureds having to pay higher premiums than would otherwise be necessary.

Benefit periods may extend during sickness or disability either for a stated term such as 2 years, 5 years or to a stipulated age such as 65, or, in some cases, for life. Benefits continue as long as the insured is disabled in accordance with the terms of the insurance policy under which he or she is insured. The definitions of disability vary among different insurance companies.

Coverage ends when an employee ceases employment with the company.

Individuals

Long-term sickness or disability income protection plans are also available to individuals who are not members of recognized groups.

Individuals applying for this type of coverage must meet certain eligibility requirements. These include health and occupational criteria. Should the individual not meet the requirements as stipulated, coverage may be denied or, while coverage may be granted, a particular hazard may be excluded.

The waiting period for benefits is stipulated in the plan contract. If short-term coverage has also been purchased, eligibility for benefits under a long-term plan will not commence until the benefits under the short-term plan

have ceased. If the long-term plan is not co-ordinated with a short-term plan the normal waiting period for benefits to begin is 30 days.

The level of benefits is stipulated in the contract of insurance and is usually a percentage of income, payable monthly. Insurance companies attempt to integrate benefits under the long-term policy with other benefits to which the insured is entitled. This is done so that the level of benefits received by the insured will equal a certain percentage of take home pay, usually 65% to 75%

The duration of benefits under this type of plan for individuals depends on occupational classification and is written most commonly for terms of 2 years, 5 years or to age 65.

Survivor Income Insurance Plans

Certain insurance companies offer survivor income insurance. Coverage under this type of insurance begins on the employee's date of employment. Should the employee die during the term of the contract a regular income would be paid to the spouse and children. Typically the conditions which must be met in order for the spouse and children to be eligible for benefits are: the spouse must be 45 years of age or older, or if under 45 be disabled or have one or more dependent children, or the employee has at least 10 years of service with the company; the children must be unmarried, dependent and under 21 or unmarried, dependent and any age but unable to obtain a job because he or she is mentally or physically disabled. Should the conditions not be met the beneficiary receives a cash refund of the employee's contributions with interest to the date of death.

If eligible, the spouse usually receives a percentage of the employee's basic monthly earnings, usually this percentage is relatively low, say 25%. Payments to the spouse are for life but guaranteed for 10 years.

This type of plan is available to both groups and individuals who are not members of groups, although individuals are not actively solicited by most companies.

Rehabilitation Benefit Plans

Rehabilitation benefit plans are an extension of regular sickness or disability income protection plans. The rehabilitation plan is designed to encourage the disabled person to return to full time work on a timely basis. Should the insured, during his rehabilitation and as part of the rehabilitation program, take on a less demanding job the insured receives the regular monthly disability benefit less 50% of the monthly earnings received from the rehabilitative employment.

There are not very many insurance companies offering this type of plan to groups and its availability to individuals is very limited.

E. OTHER ACCIDENT AND SICKNESS INSURANCE PLANS

In their attempts to respond to perceived consumer needs the insurance industry has developed a number of specialty type of insurance plans in addition to those already discussed, including:

Group Plans—

- accidental death and dismemberment plans;
- occupational accidental death and dismemberment plans;
- travel insurance;
- travel accident insurance for employees; and
- student accident policies.

Individual Plans—

- accidental death and dismemberment;
- travel insurance;
- business overhead expense insurance plans;
- creditor's insurance; and
- personal accident insurance sales by car rental agencies.

There are generally no pre-existing health conditions or age eligibility requirements to qualify for these plans and most plans are easily available.

Accidental Death and Dismemberment Plans

This type of coverage provides for a lump-sum payment in the event of the death of the insured person as a result of an accident. Plans of this type also provide for a percentage of that sum to be paid for dismemberment. Payment of the face amount of the policy is made under most policies in the event of the loss of both hands, both feet, one hand and one foot, or the sight of both eyes due to accidental bodily injury. Lesser percentages may be payable for the loss of a single hand or foot.

Such coverage is available on a group or individual basis and for a variety of covered periods and activities. These range from scheduled aircraft or common carrier coverage for the duration of a trip to full 24 hour coverage for all types of accidents during the term of the contract.

To qualify for benefits, death or dismemberment must occur within a specified period after the accident. The length of period has traditionally been limited to between 120 and 335 days.

Occupational Accidental Death and Dismemberment Plans

This type of insurance is similar to the accidental death and dismemberment plan. Occupational accidental death and dismemberment insurance is limited to occurrences which are occupation related. Its purpose is to provide coverage for an employee who may be subjected to a more hazardous than normal work environment.

Travel Insurance

Travel insurance products have been developed to meet the many needs travellers have for insurance. The basic types of travel insurance are:

- scheduled airline flight accident coverage for accidental death or dismemberment during the flight portion of a trip;
- common carrier coverage providing accidental death and dismemberment benefits for common carrier passenger service on land, air or water;
- all accident trip coverage providing accidental death and dismemberment benefits for a person anywhere in the world;
- trip cancellation coverage providing benefits to the insured if, for certain specified reasons, a trip must be cancelled;
- extended health care while travelling inside Canada;
- extended health care while travelling outside Canada;
- visitors to Canada extended health care plans; and
- loss of baggage, personal effects and money plans.

Travel insurance of any type is available by individual coverage or by group coverage. Group coverage is the preferred and most efficient method of providing insurance to groups travelling together.

Travel Accident Insurance

This type of coverage is designed to compensate the employee who may be subjected to additional risk when asked to travel on business. The type of coverage offered is accidental death and dismemberment and is usually available from date of employment and ceases on termination of employment.

Business Overhead Expense Insurance

This type of coverage is available to individuals owning businesses and who wish to have expenses such as rent of business premises, utilities, office payroll and other regular business outlays covered by insurance during the sickness or disability of the key employee.

Student Accident Policies

This type of coverage provides students with accidental death and dismemberment insurance against injuries received at or while going to and from school and in some cases provides protection 24 hours a day on a year round basis.

Creditor's Insurance

This type of coverage provides for the payment of loan instalments while the borrower is disabled, and pays off the balance if the borrower dies.

Personal Accident Insurance Sales by Car Rental Agencies

This type of insurance is sold to car rental customers and covers accidental bodily injuries and accident death sustained in an accident during the term of the agreement. A customer's passengers are also covered during the term of the agreement for the time that they are actually riding in the vehicle.

The policy term is usually from the moment the vehicle is rented to the time it is returned to the rental agency.

Benefits are stipulated in the contract and are for lump-sum amounts as set out in the contract.

CHAPTER 6

Private Organizations Participating in the Disability Financial Protection System

A. INTRODUCTION

The private organizations offering plans for medical care, dental care, income protection during periods of disability and other accident and sickness insurance products, in Ontario, must be licensed to carry on business under either The Insurance Act or The Prepaid Hospital and Medical Services Act.

B. NON-PROFIT PREPAID MEDICAL CARE ORGANIZATIONS

The non-profit prepaid medical care organizations carrying on business in Ontario are governed by The Prepaid Hospital and Medical Services Act and must report to the Superintendent of Insurance for the Province of Ontario. These organizations may be incorporated for the purpose of establishing, maintaining and operating a hospital service or medical service or providing prescription drugs on a non-profit prepayment basis. In 1980 there were five such organizations licensed in Ontario and reporting to the Superintendent:

- The Ontario Blue Cross, a division of the Ontario Hospital Association;
- Green Shield Prepaid Services Inc.;
- Quebec Hospital Services Association;
- Co-operative Health Services of Ontario;* and
- The Credit Union Mutual Benefit Association.

These organizations offer medical care and dental care coverages for the costs of goods and services not covered by government programs. The products offered, on a group basis, are:

- extended health care plans;
- prescription drug plans;
- dental care plans;
- vision care plans;
- health care while outside Canada;
- health care for visitors to Canada;
- hearing aid plans;
- nursing home plans;

*During 1981, the Superintendent petitioned the court to wind-up Co-operative Health Services of Ontario. The organization is presently being liquidated. Further reference to this matter is made in Part VI of this Report.

- nursing care plans; and
- hospital money plans.

The coverages available to individuals are: extended health care plans, health care while outside Canada and health care for visitors to Canada. Blue Cross and, commencing in the latter part of 1980, Green Shield are the only non-profit prepaid medical care organizations offering extended health care plans to individuals.

The non-profit prepaid medical care organizations do not offer income protection plans.

C. ACCIDENT AND SICKNESS INSURERS

Those organizations offering accident and sickness insurance in Ontario under the regulations of The Insurance Act include life and general insurance companies, fraternal societies and mutual benefit societies.

Set out in Appendix C is a listing of the 319 insurers licensed to transact accident, sickness and accident and sickness insurance in Ontario as at July 26, 1980.

The plans offered by the accident and sickness insurers include medical care plans, dental care plans, sickness or disability income protection plans and other accident and sickness insurance plans. The plans offered are:

- extended health care plans;
- out of country medical expense plans;
- drug expense plans;
- vision care plans;
- hearing aid plans;
- dental care plans;
- short-term and long-term sickness or disability income protection plans;
- survivor income protection plans;
- accidental death and dismemberment plans;
- occupational accidental death and dismemberment plans;
- travel insurance plans;
- travel accident insurance plans;
- rehabilitation benefit plans;
- business overhead expense insurance plans;
- student accident plans;
- creditor's insurance plans; and
- accident insurance plans offered by car rental agencies.

Most of the above mentioned plans are offered on both a group and an individual basis. The plans which are not offered to individuals are vision care plans, hearing aid plans, drug expense plans, dental care plans, occupational accidental death and dismemberment plans and student accident plans.

D. FRATERNAL SOCIETIES AND MUTUAL BENEFIT SOCIETIES

Fraternal societies are organizations incorporated for the purpose of making, on a non-profit basis, contracts of life, accident or sickness insurance with their members. As at July 26, 1980 there were 38 fraternal societies, of which 24 offered either or both accident and sickness insurance (See Appendix D). In that year there were also 51 mutual benefit societies, operating for the purpose of providing sickness and funeral benefits for their members. Set out in Appendix E is a listing of the mutual benefit societies as at July 26, 1980.

F. VOLUME OF BUSINESS

There is a dearth of meaningful statistical information concerning the volume of business, claims experience, expenses and similar matters regarding the private sector participants in the disability income protection system in Ontario. From the information that is available either with the Ontario or federal Superintendents of Insurance or with industry associations, it is impossible to develop an accurate assessment of such matters as the number of persons covered by various types of plans, the extent of coverage, and the profitability of particular coverages. It is also very difficult to make other than the most general of observations regarding the trends in the participation of the insurance companies and the non-profit prepaid medical care organizations in various segments of the market and the proportion of group and individual coverage provided. Indeed, it has been necessary for the Committee to resort to developing its own estimates based on data available from a number of sources.

The Committee has commented in previous Reports on its dismay that data concerning such an important industry as insurance are not prepared and analyzed regularly by industry participants and the Superintendent.

The data developed by the Committee concerning estimated premiums earned by insurance companies and non-profit prepaid medical care organizations for the years ended December 31, 1975 to 1979 are summarized on the table on the following two pages. The bases of the estimates are outlined in the notes at the foot of the table.

ESTIMATED PREMIUMS EARNED IN
ONTARIO BY INSURANCE COMPANIES AND
NON-PROFIT PREPAID MEDICAL CARE ORGANIZATIONS*

FOR THE YEARS ENDED DECEMBER 31

MEDICAL CARE PLANS

	1979 (\$'000)	1978 (\$'000)	1977 (\$'000)	1976 (\$'000)	1975 (\$'000)
Groups					
Insurance Industry	94,780	79,440	66,070	58,190	49,170
Non-Profit Prepaid Medical Care Organizations	96,510	89,150	86,990	86,990	77,810
Total	<u>191,290</u>	<u>168,590</u>	<u>155,640</u>	<u>145,180</u>	<u>126,980</u>
Individuals					
Insurance Industry	340	300	260	230	360
Non-Profit Prepaid Medical Care Organizations	36,190	31,460	22,000	15,240	10,600
Total	<u>36,530</u>	<u>31,760</u>	<u>22,260</u>	<u>15,470</u>	<u>10,960</u>
Total Medical Care Plans					
Insurance Industry	95,120	79,740	66,330	58,420	49,530
Non-Profit Prepaid Medical Care Organizations	132,700	120,610	111,570	102,230	88,410
Total	<u>227,820</u>	<u>200,350</u>	<u>177,900</u>	<u>160,650</u>	<u>137,940</u>

DENTAL CARE PLANS

Groups					
Insurance Industry	128,230	88,780	66,070	41,080	26,030
Non-Profit Prepaid Medical Care Organizations	68,360	54,200	45,570	37,800	29,500
Total	<u>196,590</u>	<u>142,980</u>	<u>111,640</u>	<u>78,880</u>	<u>55,530</u>

INCOME PROTECTION PLANS

Short-term					
Groups					
Individuals	150,700	140,930	131,000	118,310	103,090
Total	<u>3,420</u>	<u>3,210</u>	<u>2,320</u>	<u>2,190</u>	<u>1,730</u>
	<u>154,120</u>	<u>144,140</u>	<u>133,320</u>	<u>120,500</u>	<u>104,820</u>
Long-term					
Groups					
Individuals	144,790	130,090	120,910	100,780	87,820
Total	<u>39,300</u>	<u>36,930</u>	<u>30,850</u>	<u>29,090</u>	<u>22,940</u>
	<u>184,094</u>	<u>167,020</u>	<u>151,760</u>	<u>129,870</u>	<u>110,760</u>
Short-term and Long-term					
Groups					
Individuals	295,490	271,020	251,910	219,090	190,910
Total	<u>42,720</u>	<u>40,140</u>	<u>33,170</u>	<u>31,280</u>	<u>24,670</u>
	<u>338,210</u>	<u>311,160</u>	<u>285,080</u>	<u>250,370</u>	<u>215,580</u>

OTHER ACCIDENT AND SICKNESS INSURANCE PRODUCTS

Accidental Death and Dismemberment					
Groups	16,730	14,020	12,390	10,270	8,680
Individuals	20,670	18,480	14,290	12,600	8,940
Total	<u>37,400</u>	<u>32,500</u>	<u>26,680</u>	<u>22,870</u>	<u>17,620</u>
Other Types of Accident and Sickness					
Insurance Products					
Groups	22,300	14,020	16,520	13,690	14,460
Individuals	5,510	5,100	3,570	2,800	1,790
Total	<u>27,810</u>	<u>19,120</u>	<u>20,090</u>	<u>16,490</u>	<u>16,250</u>
Total Other Accident and Sickness Insurance Products					
Groups	39,030	28,040	28,910	23,960	23,140
Individuals	26,180	23,580	17,860	15,400	10,730
Total	<u>65,210</u>	<u>51,620</u>	<u>46,770</u>	<u>39,360</u>	<u>33,870</u>
AUTOMOBILE PERSONAL ACCIDENT					
	<u>68,910</u>	<u>61,030</u>	<u>55,670</u>	<u>50,850</u>	<u>44,110</u>
TOTAL PREMIUMS EARNED IN ONTARIO					
Groups	722,400	610,630	548,100	467,110	396,560
Individuals	174,340	156,510	128,960	113,000	90,470
Total	<u>896,740</u>	<u>767,140</u>	<u>677,060</u>	<u>580,110</u>	<u>487,030</u>

* Notes

- 1) Premiums earned by insurance companies were estimated as follows:
 - premium written information was extracted from the annual reports of the Superintendent of Insurance for Ontario,
 - premiums earned were calculated assuming that premiums were written evenly throughout the year, and
 - breakdowns by type of coverage were estimated using information provided by the Superintendent of Insurance for Ontario.
- 2) Premiums earned by non-profit prepaid medical care organizations were estimated as follows:
 - premiums earned information was extracted from the annual reports of the Superintendent of Insurance for Ontario,
 - premiums earned by Blue Cross in 1975 and 1976 were reported on a calendar year basis; in 1977 Blue Cross changed its year end to June 30, premiums for 1977 have been annualized; premiums earned in 1978 and 1979 are included on a June 30 year end basis,
 - premiums earned by Co-operative Health Services and Cumbs are included on a June 30 and August 31 year end basis, respectively, and
 - breakdowns by type of product, group and individual were based on information provided by Blue Cross.
- 3) Estimated premiums earned by Fraternal Societies and Mutual Benefit Societies have not been included; they represent less than $\frac{1}{2}$ of 1% of the total premiums earned in Ontario in any year.

A review of the data contained in this table indicates:

- total premiums earned in Ontario by all organizations increased at an average of 16.5% a year in the period 1976 to 1979 with a high of 19.1% in 1976 and a low of 13.3% in 1978;
- the proportion of group premiums of the total remained at about 81% and individual premiums at 19% throughout the period;
- the proportion of total premiums earned by non-profit prepaid medical care organizations decreased from 24.2% in 1975 to 22.4% in 1979;
- the annual growth of the premiums earned by the non-profit prepaid medical care organizations has been 10.3% in 1976, 20.8% in 1977, 11.2% in 1978 and 15.0% in 1979 for an average of 14.1% throughout the period;
- this compares with an average growth throughout the period in premiums earned by insurance companies of approximately 17%;
- medical care plans represent 25.4% of total premiums earned in 1979 compared with about 28.3% in 1975;
- dental care plans on the other hand represented only 11.4% of premiums earned in 1975 but 21.9% in 1979, an average annual increase in premiums earned over the period of better than 37%; and
- income protection plans represent the largest portion of total premiums earned amounting to about 37.7% of the total in 1979 down however from better than 44% of the total in 1975.

CHAPTER 7

Medical Care Plans

A. INTRODUCTION

Medical care benefit plans provided by insurance companies and non-profit prepared medical care organizations in Ontario offer coverage for many of the products and services not covered by governmental plans. The types of coverages offered were discussed in Chapter 5. In this chapter the medical care plans offered by insurance companies and by the non-profit prepaid medical care organizations are examined with the aim of highlighting the volume of these plans written in Ontario analyzed further by group and individual coverage. Also described are the underwriting procedures followed by these organizations and their claim handling procedures.

B. VOLUME OF BUSINESS

TABLE 2

ESTIMATED PREMIUMS EARNED IN ONTARIO BY INSURANCE COMPANIES AND NON-PROFIT MEDICAL CARE ORGANIZATIONS

MEDICAL CARE PLANS					
For the Year Ended December 31					
	<u>1979</u>	<u>1978</u>	<u>1977</u>	<u>1976</u>	<u>1975</u>
	(\$'000)	(\$'000)	(\$'000)	(\$'000)	(\$'000)
Group					
Insurance Industry	94,780	79,440	66,070	58,190	49,170
Non-Profit Prepaid Medical Care Organizations	<u>96,510</u>	<u>89,150</u>	<u>89,570</u>	<u>86,990</u>	<u>77,810</u>
Total	191,290	168,590	155,640	145,180	126,980
Individual					
Insurance Industry	340	300	260	230	360
Non-Profit Prepaid Medical Care Organizations	<u>36,190</u>	<u>31,460</u>	<u>22,000</u>	<u>15,240</u>	<u>10,600</u>
Total	<u>36,530</u>	<u>31,760</u>	<u>22,260</u>	<u>15,470</u>	<u>10,960</u>
Total Medical Care Plans					
Insurance Industry	95,120	79,740	66,330	58,420	49,530
Non-Profit Prepaid Medical Care Organizations	<u>132,700</u>	<u>120,610</u>	<u>111,570</u>	<u>102,230</u>	<u>88,410</u>
Total	<u>227,820</u>	<u>200,350</u>	<u>177,900</u>	<u>160,650</u>	<u>136,940</u>

Note: This table has been reproduced from Table 1. The notes included with Table 1 also apply to this table.

Analyses of these data indicate:

- total medical care plans premiums earned increased at an average annual rate of 12.5% in the period 1976 to 1979;

- of this increase, the insurance industry experienced the greater growth rate at an average of about 18% per annum with the non-profit prepaid medical care organizations showing an average annual increase of about 11%;
- nevertheless, the non-profit prepaid medical care organizations continue to account for the greater proportion of premiums earned for medical care plans at 58% in 1979 although their share is down from 64% in 1975;
- the sales of medical care plans is mainly to groups which account for 84% of premiums earned by all providers in 1979;
- in 1979, sales to groups are almost equally divided between the insurance industry and the non-profit prepaid medical care organizations; in earlier years the latter organizations had a more dominant share of the market; and
- the participation of the insurance industry in the marketing of medical care plans is merely token in spite of the fact that in 1979 there were premiums written for this coverage of more than \$36 million or some 16% of the total premiums written for medical care coverage by the private sector.

C. GROUP UNDERWRITING, RISK SELECTION AND PRICING PROCEDURES

The underwriting process involves, as its most important function the identification and evaluation of characteristics which help assess the risks involved in issuing a policy of insurance. This section deals with the types of groups covered, group selection theory and with the factors used in assessing the various risk factors involved in writing group medical care plans by insurance companies and non-profit prepaid medical care organizations.

Types of Groups

Generally the four main types of groups which are eligible for group insurance are:

- Employer/Employee groups;
- Employer Association groups;
- Union; and
- Creditor groups

By far the most important is the employer/employee group and as such the comments which follow concentrate on this type of group.

Group Selection Theory

Theoretically, the group concept provides an effective means of offering insurance coverage to a collection of individuals without the need for

evidence of insurability. The success of the approach relies upon the ability to obtain a group of persons, or more importantly, an aggregation of such groups that will yield a certain predictable rate of claims cost. If there is a sufficient mass of risk groups and if they are reasonably homogeneous in nature, then such predictability should occur.

To ensure homogeneity an insurer attempts to see that certain essential features are present in the group. For example, the organization requiring group insurance should exhibit the following characteristics:

- it should be reasonably permanent in nature;
- its members should have some strong bond to hold them together, usually mutual financial gain;
- the group must be formed for reasons other than obtaining insurance, to prevent anti-selection; and
- there must be a steady flow of new entrants and the rate of turnover must be reasonable.

Further, in order to ensure a predictable spread of risk, most insurance companies require that at least 75% of those eligible for insurance must apply for coverage. Insurers also want some financial contributions on the part of the employer towards the group plan, since in their view if this condition is not met, the younger employees will probably not join the plan causing a decrease in the spread of risk. Generally, insurers believe it is not satisfactory to have employees contribute at a level greater than 75% of the cost of the plan and most plans today have the employer paying at least 50% of the cost if not more.

Other underwriting requirements are also imposed including:

- an employee be actively-at-work for full pay on the day he became insured and that his dependants not be confined to hospital on that day. The definition of full-time employees varies from employer to employer but the normal work week is usually considered to be not less than 30 hours. Temporary, seasonal and part-time employees are not normally eligible. Also excluded are such personnel as lawyers and accountants not directly on the payroll of the policyholder but performing work on behalf of an outside firm;
- the employee's type and amount of coverage be determined according to the insurance schedule in the master policy.

Evidence Requirements

Many insurers also insist that certain additional requirements be met for circumstances beyond the norm. For example, a statement of health may be required for employees who were absent from work due to illness in some defined period. Most plans provide for non-evidence limits for disability income coverages which generally depend on the total volume of insurance on

the group as well as, in some cases, the average benefit insured. However, where amounts of coverage applied for by employees in the group exceeds the non-evidence limit, such excesses become subject to the submission of satisfactory evidence of insurability. Practices will vary by insurers depending upon the benefit in question but commonly may include one or more of—health declarations or questionnaires; attending physician reports; paramedical examinations; and, independent medical examinations. It is also common practice to require satisfactory evidence of insurability on so called “late applicants”—employees applying for coverage more than 31 days beyond their date of eligibility.

On the grounds of attempting to minimize administrative expenses and plan abuse, insurers usually require new employees be employed on a full time basis for a probationary period, such as three months, before becoming eligible for insurance. A somewhat longer period may be imposed on groups with a history of high staff turnover.

Termination of Coverage

An employee’s coverage terminates automatically:

- when he is no longer a member of an eligible class insured;
- if he fails to make a required contribution;
- upon termination of employment; or
- upon policy termination by non-payment of premiums or otherwise.

Dependant coverage terminates when an employee’s insurance terminates and also at the time that the dependant no longer qualifies in accordance with the dependant definition in the plan, such as limiting age, or dependancy status.

Some insurance companies provide for coverage of insurance during temporary leave or lay-off. This is possible if the employer, acting on a basis precluding individual selection, continues the employee’s insurance with the premium payments required for a defined temporary period of time. Generally, a limit is set of the end of the third policy month following the temporary lay-off or leave of absence.

An employee is considered as employed on a full-time basis during a period of disability provided the employer continues his coverage.

Risk Factors

Once the insurer has established that a group meets its standard underwriting requirements it evaluates the risk under each benefit to be provided to establish a rate for the coverage. Generally, insurance companies maintain basic rates based upon information obtained from a review of claims experience for similar plans of their own, industry experience and any other

actuarial studies which may be available. The basic rate structures are then modified to recognize the unique characteristics of the group under review.

The risk factors usually considered by the insurance industry are age, sex, maternity coverage, geographic area of residence, occupation of individuals in the group and in some cases, the industry in which the employer operates. The insurance industry's attitudes regarding these matters are summarized below.

Age

The incidence of claims generally increases with age under income replacement and medical care coverages except that there is a reduced risk of claims by retired lives for certain prescription drugs because government plans provide most drugs free to persons over 65.

Generally, an expanding industry that is hiring young employees, or an inherently younger group such as bank tellers, would have a lower rate structure for medical care coverage than groups with older age distributions.

Sex

The insurance industry believes that females generally exhibit higher claims costs than males under income protection plans, medical care plans and basic dental plans. The additional risk, however, is not necessarily constant for each age and some insurers will reflect this in their premium rate determination.

Maternity Coverage

The extent of the maternity coverage available in the benefit causes an extra loading on the rate structure and is considered as a separate aspect in rating.

Geographic Area

The area in which the group is located has a bearing on the claims rate expected. Provincial medical and dental fee schedules and availability of treatment are reflected in this adjustment. As an example of different geographic adjustments, a group of loggers working in northern Ontario with limited access to dental treatment would be charged lower rates than a group located in a metropolitan area with good access to dentists.

Industry Hazard

Certain industries exhibit special hazards which result in a special loading from the norm. Examples of hazardous industries are the chemical industry, industries using explosives, and those involved in natural gas transmission.

Occupational Coverage

Many insurers require an occupational loading either for some particularly hazardous occupations within the industry or for unique rating problems within certain occupations. This is separate from the industry hazard in that not all members within an employee group will be involved. For example, underground miners receive a special loading for hazardous occupation which is not extended to the total mine operation. Teachers and sales personnel represent an unique costing problem for dental coverage as they are much more aware of their appearance, and tend to use preventive dentistry more and are charged rates to reflect this fact.

Dependant Definition

Generally, insurance companies start with a standard dependant definition and institute either a loading or discount based on the modification of the dependent child definition required by the policyholder.

Premium Volume

As a group grows in size, administrative cost decreases as a percentage of the premium level. This decrease in administrative cost may be reflected in a volume discount.

Pricing Procedures

The foregoing comments addressed the various rating considerations used in establishing the initial premium rates for a group contract. In essence they reflect the expected claims experience of the group. On renewals of coverage insurers, when dealing with large groups, place more reliance on the experience of the particular group; the insurers resort more to "experience rating".

When establishing the renewal rates for small groups, fewer than 50 lives, the actual claims experience of individual groups is not reflected in its rate determination. Rather, the claims experience of a number of aggregations of such groups, usually referred to as pools, will be used to determine the expected claims experience applicable to each group within a pool. Pools may be formed according to various criteria such as the number of lives, geographic area or renewal date and there is considerable diversity among insurers in this regard. The insurance benefits offered to these groups tend to be packaged or standardized in order to reduce administrative expense, create homogeneity of risk within each pool, and streamline the sales function.

Usually in the case of medium sized groups, 50 to 500 or 1000 lives, a group's own claims experience will be used to determine its renewal rates, particularly for medical care plans. The degree to which past claims experience will influence final premium rates is usually determined according

to credibility formulae. These formulae vary by insurer but generally depend upon factors such as, the accumulated number of lives exposed, premium volume and claims experience over recent periods of time.

The above highlights the methods used by insurers in the determination of prospective premium rates for groups or group pools for the coming policy year. Pricing formulae must also be developed and used in determining to what extent premiums for the last policy year exceeded or fell short of those which were required to fund actual claims and expenses. For small or pooled groups, it is the performance of each pool that is evaluated. Any excess or shortfall will generally be reflected in the pool's premiums for the next policy year. For groups of medium and large size, the evaluations are often made on an individual group basis. Expenses actually incurred are usually allocated according to a formula designed to represent reasonably the distribution of such expenses by group. Excess premiums, if any, are usually applied first against any losses carried forward from prior years on the group with the balance either paid to the policyholder in cash or applied against premiums for the next policy year. Premium deficiencies are generally carried forward for recovery out of premium excesses in future years.

D. UNDERWRITING, RISK SELECTION AND PRICING PROCEDURES FOR INDIVIDUAL MEDICAL CARE PLANS OF INSURANCE

Insurance companies do not actively market medical care plans to individuals. However, there are certain insurance companies which will sell this type of insurance to individuals on request. Premiums earned by insurance companies from the sale of medical care plans to individuals in 1979 was approximately \$340,000, which represented only $\frac{1}{3}$ of 1% of the premiums earned by insurance companies for medical care plans and 1% of the premiums earned by both insurance companies and the non-profit prepaid medical care organizations on the sale of such plans to individuals in that year.

For those insurance companies which will occasionally write this type of insurance for individuals the underwriting, risk selection and pricing procedures are similar to the procedures followed by insurers writing individual sickness or disability income protection plans as discussed later in Chapter 5 of this Part. More attention will be paid to the applicant's statement of health and any pre-existing conditions will probably be excluded from coverage.

E. NON-PROFIT PREPAID MEDICAL CARE ORGANIZATIONS

Underwriting and risk selection procedures followed by the non-profit prepaid medical care organizations in underwriting medical care plans for "new groups" vary somewhat with the procedures followed by insurers in that special risk categories such as age, industry, occupation or medical

background are not considered in arriving at the appropriate level of premium for a new group. Standard “new group” rates are calculated for each type of benefit program based on the non-profit prepaid medical care organization’s overall experience with the plan being offered. However, if information can be obtained from the employer relating to the group’s previous experience it may be used to adjust the applicable standard rate. Once a group has been in existence for a certain period of time the renewal rates will be based on the group’s experience in much the same way as insurance companies’ experience rate.

The pricing procedures followed by the non-profit prepaid medical care organizations are based on a “break-even” principle. The revenue received from all sources including investments, will equal the claims incurred, plus the actual cost of administering the program and the necessary allocation to reserves. In the case of group pricing, the group could be employees of a single company covered for a specific type of benefit, or a pooled group of employees with a number of companies whose collective experience for the same period of benefit is combined.

Renewal rates for both groups and individuals are calculated on current experience of claims paid, reserve requirements and administration costs. The amount of reserves required varies from plan to plan, based on the actual benefit and the deductible or co-payment factors involved in each.

Those non-profit prepaid medical care organizations which offer medical care plans to individuals do not follow the procedures followed by insurance companies. Medical care coverage is offered by non-profits to individuals at the same rate for *all* regardless of the level of risk which a person might present by virtue of age, pre-existing condition or medical history. However, in order to prevent “anti-selection”, these plans are available to individuals at certain stipulated dates during the year for a period of about 6 weeks.

F. CLAIMS HANDLING PROCEDURES

A major function of the medical care plan provider is to set up a mechanism to pay claims in the event the insured suffers a loss. This mechanism must satisfy the provider that claim payouts are for valid claims and must satisfy the claimant that he or she has been fairly compensated.

The ultimate test of any group benefit package or any purchase of individual insurance must be the sensitivity to employee or insured needs and the speed of response to individual claims. In order for a policy to be effective where benefits become payable they should be paid promptly and with a minimum of red tape.

The medical care plan claims handling procedures for groups and individuals are described below.

Group Medical Care Plan Claims Handling Procedures

In order for claims to be handled efficiently there must be good co-ordination and communication between the insurer, the employer or policyholder and the employee insured. Many large employers maintain their own claims departments and claims records and in fact initiate the claims handling procedure. To achieve employee satisfaction many companies work continuously with their employees to ensure that the insurance programs are understood and that there are no surprises in the claims settlement process. From the provider's point of view when the policyholder acts as intermediary, as employer he will validate the eligibility for a claim and offer a certain degree of control.

Claim forms under most plans are supplied to the employer by the provider. The employee completes his section of the form and provides the proof of claim such as drug bills. The employer's section of the form is completed by the administrator.

Coverage is verified and the provider prepares a cheque for an amount which recognizes any applicable deductible, co-insurance feature and maximum benefit limitation under the plan. Some plans may include a co-ordination of benefits clause which provides that payment can be adjusted so that the total reimbursement from all plans shall not exceed 100% of actual allowable expenses.

A relatively recent innovation in this field has been the "pay-direct" drug benefit. As the name implies, this system obviates the necessity for submission of prescription drugs claims information to the insurer by the employee. Instead, the pharmacist will periodically submit such data and receive reimbursement directly from the insurer. The convenience of this type of plan has meant that it is being used more and more frequently in recent years.

Hospital claims, as a general rule, are submitted directly to the insurer by the hospital. The benefit payment is sent to the hospital but if it is less than the total charges, the hospital bills the employee for the difference.

Individual Medical Care Plan Claims Handling Procedures

Claims handling procedures for individual plans are generally the same as under group plans, with the exception of the need on the part of the provider to ensure that individual contract conditions have been met.

Usually the insured will request a claim form from the provider. The insured then fills the claims form out, obtains a physician's statement or other supporting information and submits the claim. In those instances where the information submitted is incomplete or it is necessary to clarify any

information, the claims examiner will contact the party involved. Once the claim is approved a cheque is mailed to the claimant.

The matter of pre-existing conditions is of prime importance in the settlement of claims under individual contracts of insurance with insurance companies. Generally medical conditions declared in the insured's contract are covered unless specifically waived or limited by the insurer when the policy is issued. Undeclared conditions are a problem and claims may be denied because the applicant knowingly or inadvertently failed to reveal significant medical history when applying for insurance.

CHAPTER 8

Dental Care Plans

A. INTRODUCTION

Dental care plans are a relatively recent addition to the system of sickness or disability financial protection in Ontario. These plans have become very popular and are now being offered as a standard part of many employee/employer group packages of insurance. However, dental care plans are only available to groups. The providers have not yet devised an acceptable method of making this coverage available on an individual basis.

This chapter deals with dental care plans from the perspective of the volume of business written in Ontario, the underwriting practices followed by the providers and their claims handling procedures. Many of the comments made in the chapter on medical care plans also apply to dental care plans and as such will not be repeated.

B. VOLUME OF BUSINESS

TABLE 3

ESTIMATED PREMIUMS EARNED IN ONTARIO BY INSURANCE COMPANIES AND NON-PROFIT PREPAID MEDICAL CARE ORGANIZATIONS

DENTAL CARE PLANS					
For the Years Ended December 31					
	1979	1978	1977	1976	1975
	(\$'000)	(\$'000)	(\$'000)	(\$'000)	(\$'000)
Group					
Insurance Industry	128,230	88,780	66,070	41,080	26,030
Non-Profit Prepaid Medical Care Organizations	<u>68,360</u>	<u>54,200</u>	<u>45,570</u>	<u>37,800</u>	<u>29,500</u>
Total	<u>196,590</u>	<u>142,980</u>	<u>111,640</u>	<u>78,880</u>	<u>55,530</u>

Note: This table has been reproduced from Table 1. The notes included with Table 1 also apply to this table.

Total premiums earned over the period December 31, 1975 to December 31, 1979 have increased at an average annual rate of approximately 37%, with the insurance industry experiencing the most rapid growth averaging nearly 50% per annum over the period. As a result premiums earned by insurance companies increased from 47% of the total in 1975 to 65% in 1979.

C. GROUP UNDERWRITING, RISK SELECTION AND PRICING PROCEDURES

The underwriting procedures followed by insurance companies, in providing dental care plan coverage, are similar to those procedures for

medical care plans outlined in the preceding chapter. The differences peculiar to dental care coverages are summarized below.

Special provisions such as statements of health for employees absent from work due to illness in some defined period which are required by many insurers in underwriting medical care plans do not apply in underwriting dental care coverages. However, there is usually a clause in a dental care plan contract which restricts benefit payments in respect of treatments for teeth missing at the effective date of the insured person's coverage. This clause excludes the cost of replacing such teeth from eligible expenses under the plan. Further, satisfactory evidence of insurability is required on late applicants in order to avoid anti-selection.

Insurance companies, after establishing the standard underwriting requirements will also evaluate the risk under a dental care plan. The risk factors analysed are the same as for medical care plans however the emphasis is different, for example; the risk under basic dental coverages, procedures related to prevention and maintenance, tends to be highest at younger ages and generally reduces with increasing age. Under major restorative coverages, however, the risk is more closely correlated to that for extended health care coverages. The female content of the group affects rates, as females are considered to be more conscious of their appearance than males. Industry hazard is not as important in determining rates for dental care plans as it is for medical care plans.

The pricing procedures described under medical care plans also apply to dental care plans. The basic rates and renewal rates will be changed and reviewed more often than other plans as dental care costs have been rising quickly in the past few years and as such the premium rates must be adjusted to reflect the increases.

The non-profit prepaid medical care organizations offer dental care plans on a group basis only. The underwriting policies are, as explained in the preceding chapter, based on a standard "new group" concept and the special risk categories used by the insurance industry are not applicable.

D. CLAIMS HANDLING PROCEDURES

The claims handling procedures followed by the insurance industry and the non-profit prepaid medical care organizations are similar in nature. The claiming employee obtains a copy of a standard claims form from his employer which is completed by the dentist showing the services provided and the fee for each. The standard dental claim form is a form jointly designed and approved by the Canadian Dental Association and the Canadian Life and Health Insurance Association.

The applicable sections of the claim form are completed and mailed to the insurer. The claims representative reviews the claim, with the help of a

dental consultant, if necessary. The claims representative will usually compare the fee charged with those in the Ontario Dental Association schedule of fees guide to determine eligible expense amounts. The benefit payment will reflect the applicable deductibles, co-insurance percentages and maximum benefit limitations of the plan.

When the claim is approved, a cheque is made payable to the employee although in some cases it may have been assigned to the dentist, in which case the latter is the payee.

It is common practice for insurers and for non-profit prepaid medical care organizations to “pre-determine” benefits where the cost of services is going to exceed a limit such as \$100 or \$200. Prior to treatment, the proposed procedure is evaluated by the provider to determine the amount which the plan will pay. The purpose of this approach is to avoid after-the-fact disappointment in cases where the plan payment is less than the employee anticipates.

Part of the claims settling procedures is also the matter of co-ordination of benefits. The insurance industry, in co-operation with non-profit prepaid medical care organizations, have introduced a co-ordination of benefits provision to ensure that no covered individual will receive benefits more than he has paid for dental service and to ensure that no provider of dental care plans will pay more than is required on its own contract.

CHAPTER 9

Income Protection During Periods of Sickness or Disability

A. INTRODUCTION

Premiums earned by insurance companies in Ontario in 1979 from sickness and disability income protection plans have been estimated at approximately \$338 million and represent close to 49% of the total premiums earned by those companies from all disability financial protection plans. Plans are designed to offer income protection to groups and individuals, however, group plans result in the largest source of business and are generally readily available. The availability of these plans to individuals is limited to a large extent because no efficient method of marketing them on an individual basis has been developed. Sickness or disability income protection plans are not offered by the non-profit prepaid medical care organizations.

This chapter deals with income protection during periods of sickness or disability under the following headings:

- volume of business;
- underwriting, risk selection and pricing procedures as they apply to individuals;
- group claims handling procedures; and
- participants in the claims handling process.

The underwriting, risk selection and pricing procedures practised by insurance companies offering group income protection during periods of sickness or disability are the same as those followed for medical care plans and have been dealt with in the chapter on medical care plans. Claims handling procedures practised by insurance companies in their dealings with individuals have also been described in the section dealing with medical care plans and will not be repeated here.

B. VOLUME OF BUSINESS

Set out in Table 4 below is an extract from the Table 1 included in Chapter 6 which summarizes estimated premiums earned in Ontario by insurance companies for group and individual sickness or disability income protection plans in the years 1975 to 1979:

TABLE 4
ESTIMATED PREMIUMS EARNED IN
ONTARIO BY INSURANCE COMPANIES

INCOME PROTECTION PLANS
For the Years Ended December 31

	<u>1979</u>	<u>1978</u>	<u>1977</u>	<u>1976</u>	<u>1975</u>
	(\$'000)	(\$'000)	(\$'000)	(\$'000)	(\$'000)
Short-term					
Group	150,700	140,830	131,000	118,310	103,090
Individual	<u>3,420</u>	<u>3,210</u>	<u>2,320</u>	<u>2,190</u>	<u>1,730</u>
Total	<u>154,120</u>	<u>144,140</u>	<u>133,320</u>	<u>120,500</u>	<u>104,820</u>
Long-term					
Group	144,790	130,090	120,910	100,780	87,820
Individual	<u>39,300</u>	<u>36,930</u>	<u>30,850</u>	<u>29,090</u>	<u>22,940</u>
Total	<u>184,094</u>	<u>167,020</u>	<u>151,760</u>	<u>129,870</u>	<u>110,760</u>
Short-term and Long-term					
Group	295,490	271,020	251,910	219,090	190,910
Individual	<u>42,720</u>	<u>40,140</u>	<u>33,170</u>	<u>31,280</u>	<u>24,670</u>
Total	<u>338,210</u>	<u>311,160</u>	<u>285,080</u>	<u>250,370</u>	<u>215,580</u>

Note: This table has been reproduced from Table 1. The notes included with Table 1 also apply to this table.

Total premiums earned from the sale of sickness or disability income protection plans has risen at an average annual rate of about 12% over the 1975-1979 period. Premium earned from the sale of short-term plans and long-term plans have increased at an average annual rate of 10.3% and 13.2%, respectively. The rate of growth in both 1979 and 1978 was significantly lower than in the preceding two years.

Most plans are group plans. They account for almost 87¹/₂% of the estimated premiums earned by insurers from these plans in 1979.

C. UNDERWRITING, RISK SELECTION AND PRICING PROCEDURES AS THEY APPLY TO INDIVIDUALS

In general, insurance companies follow three steps in the process of underwriting individual sickness or disability income protection plans:

- they seek information about the personal risk characteristics of the applicant from a number of sources;
- they attempt to evaluate the degree of risk associated with the application, often by categorizing applications into various levels of risk; and
- they determine the appropriate premium to be paid from one or a set of premium tables.

Collection of Data

In order to determine the appropriate classification for each applicant, insurance underwriters seek information from a variety of sources, including:

- application forms;
- agent's reports;
- medical examiners;
- attending physicians;
- The Medical Information Bureau;
- investigative consumer reports; and
- internal company investigations.

The sources of information used by insurance companies writing income protection insurance are the same as are used by insurers in writing life insurance. Detailed descriptions of the sources of information are contained in the Fourth Report on the Life Insurance Industry pages 215 to 221 and will not be repeated here.

Factors Used in Risk Determination

The factors used by insurers in risk determination for individual insurance policies are much the same as those used in writing group policies. Insurers first establish a premium rate based upon a broad grouping, or classification which include sex, age and occupation. Once the first broad classification is established the applicant's eligibility for a standard rate is established by investigating the applicant's health, financial and personal situations.

Occupation

Insurers are interested in an applicant's occupation for a number of reasons:

- the risk of accident;
- the environmental conditions such as humidity, temperature, dust;
- the extent to which a minor impairment would be disabling;
- the job satisfaction of the occupation—is the insured likely to be anxious to return as quickly as possible?
- the place of work—those working in their own homes create problems for claims personnel to determine whether or not they are disabled.

To simplify the pricing process, occupations are grouped where the duties are similar, educational qualifications are much the same and motivation and earning power are alike. For example, doctors of medicine, lawyers, dentists, and others with professional qualifications are grouped as a class. Similarly, jobs requiring more manual labor, such as carpenters, plumbers, and electricians are grouped as a separate class.

Normally, insurers use five occupational groups with professional people employed full time in an office classed as low risk applicants and manual labourers high risk.

There are occupations which would be insurable for life insurance but which are considered by the insurance industry to be uninsurable for disability insurance. Examples of such uninsurable or severely extra rated risks are professional athletes, dishwashers, housewives and individuals working with explosives.

Health

The underwriter's job is to assess the applicant and, if necessary, call for more information. Certain medical information concerning the applicant is submitted at the time of application, if necessary the underwriter will ask for more information and occasionally an examination by a physician. Certain health hazards are equally significant for both life and accident and sickness insurance. Others, such as back problems, or mild nervous disorders are of major importance in underwriting a disability insurance policy and of little or no significance in underwriting a life policy. Declared medical conditions may call for some form of waiver or limitation of coverage. The underwriter is usually responsible for making this decision. In certain cases the health hazard may be serious enough to preclude insurance. Inability to obtain crucial information concerning the applicant's health is also used as a reason for declining coverage.

Moral and Ethical Standards of Applicants

Insurers view the moral and ethical standards of the applicant as important, but acknowledge that they are difficult to evaluate. A history of frequent or abnormally lengthy periods of disability paid for by workers' compensation, unemployment insurance, or group insurance are used by insurers as reasons for declining coverage to applicants on the grounds that the applicant may try to abuse the insurance coverage by making unreasonable, excessive or even false claims. Those involved in illicit activities are refused coverage. Some companies also refuse coverage to those who have suffered lengthy or repeated periods of unemployment.

Setting Premium Rates

Once the applicant has been categorized and eligibility has been assessed the underwriter has several alternatives:

- if the risk is considered standard, premium rates printed in the insurer's rate manual are used and the policy is issued as applied for; if the policy cannot be issued at standards rates, then—
- an extra premium is charged;

- a particular hazard may be excluded from coverage;
- the benefit amount may be reduced or the benefit period shortened; or
- the application may be “declined”.

D. GROUP CLAIMS HANDLING PROCEDURES

Short-term Income Protection During Periods of Sickness or Disability

Claims forms are normally required to be completed by the employer, employee and the employee’s physician and are submitted to the insurer once a waiting period has expired.

Coverage is verified by the claims reviewing staff, who may make use of medical consultants and manuals indicating expected durations of claims for various disabling conditions. If an attending physician’s report is required or an independent medical examination called for, the insurer usually pays the medical examination bill.

If the claim is approved, cheques are issued on a weekly basis in accordance with the amounts stipulated in the group contract, subject to periodic proof of continuing disability.

A typical short-term claim form includes a statement from the insured stating: when the disability commenced, expected date of return to work, how the disability occurred and the name of the attending doctor. The claim form also includes a statement from the policyholder stating: the date the insured last worked, the date the insured returned to work, details of the policy, whether or not a claim was made with Workmen’s Compensation, a statement validating the existence of a claim and a brief job description. A statement is also usually required from the attending physician stating: whether or not the condition is due to the patient’s employment, a diagnosis of the patient’s present condition, when the symptoms first appeared, the date the insured is expected to return to work and a statement regarding the patient’s ability to work.

Long-term Income Protection During Periods of Sickness or Disability

In the case of long-term income protection coverage, an employer’s statement notifying the insurer of the employee’s disability is usually submitted to the insurer some time before the expiration of the waiting period. An attending physician’s statement is also required. This is normally paid for by the insurance company.

Coverage is verified by claim reviewers who may make use of medical consultants and rehabilitation consultants for those claims where their

expertise is required. During the claim review a request may be made for supplementary information such as:

- consultation with the insured's medical doctor;
- a request for further information from the insured's attending physician and/or employer;
- an independent investigation by an outside or third party organization; and
- a medical examination by a physician.

The employer's statement to the insurer includes the following information:

- date hired;
- occupation;
- personal details such as age and sex;
- date last reported to work;
- explanation of why insured stopped working;
- description of job functions;
- summary of insured's educational background;
- summary of insured's work experience;
- salary when last actively-at-work; and
- policy information.

The attending physician's statement includes information relating to the history of the disability, diagnosis, treatment, the physical impairment, prognosis, rehabilitation details and any other remarks deemed necessary.

The employer is notified of the claim decision and, if it is approved, the initial cheque will usually accompany the notification. Future cheques are generally sent directly to the employee.

Long-term income protection contracts will specify whether Canada Pension Plan benefits and Quebec Pension Plan benefits, if applicable, are direct offsets against claim payments. If so, the insurer may estimate the amount of the CPP benefit which the employee will receive and deduct such estimate from its payments effective from the date such benefit would be expected to commence. Upon final adjudication of the CPP benefit, a retroactive adjustment is made to reflect the accumulated difference between the estimate and the approved amount. Short-term coverages generally do not offset benefit payments by CPP awards.

When long-term income protection coverages do not provide for direct offset of CPP benefits the latter may still affect the payment amount under the group contract. This is so because most insurers include an "all sources" limitation in their policies. Generally speaking, such a clause provides that the benefit otherwise payable will be reduced such that the sum of disability income payments from all sources, other than individual policies, does not exceed a predetermined percentage of earnings prior to disablement. Such

percentage is normally 80% or 85%. The purpose of the clause is to ensure the employee is not over-compensated and, indirectly, according to insurers, to provide an incentive for the disabled employee to return to work. If the employer contributes towards the cost of coverage, then the long-term benefit is taxable and the above percentage applies to the employee's gross income. If the cost of the plan is funded by employee premiums only, then the benefit is non-taxable and the percentage is usually applied to net take-home pay. Alternatively, the "all sources" limit on a non-taxable plan may be defined by some lower percentage applicable to gross earnings.

In the determination of the effect of CPP benefits upon the payment level under a group contract, it is the initial approved benefit which is used. In other words, although CPP benefits are adjusted from time to time to reflect cost of living increases, these subsequent adjustments do not alter the payment amounts under group plans.

Some long-term income protection contracts may include a "pre-existing conditions" clause as a means of claims control. Such clauses will generally exclude from coverage any disability arising during a defined period for a condition or injury which already existed at the effective date of the employee's insurance.

After a group disability claim is approved, it will be reviewed periodically to determine if it continues to qualify. Such review may include:

- an up-to-date report from the attending physician;
- an independent medical examination by a physician appointed by the insurer;
- an independent investigation by an outside or third party organization; and/or
- visitation by a claims specialist employed by the insurer.

Some insurance companies include, as part of the claim review process, the assessment of the rehabilitation potential for the employee. For those insurance companies that review rehabilitation potential the employer and employee are informed of this fact, often in the form of a descriptive booklet. Various agencies such as Canada Manpower or the Ontario Ministry of Community and Social Services may be suggested by the insurer for necessary evaluation and training. Further details concerning rehabilitation practices, not only of insurers but others in both the private and public sector, are summarized in Part III of this Report.

E. PARTICIPANTS IN THE CLAIMS HANDLING PROCESS

Doctors

Medical and dental doctors play an important role in the claims handling procedures of accident and sickness insurance.

Physicians are responsible for filling out disability forms and are faced with the task of assessment of total or partial disability. Doctors may also be retained by the insurance industry to act as consultants on the degree of impairment and also to assess whether or not the person can be rehabilitated.

Possibly the most important of the physician's tasks is to judge total or partial disability and that judgment can affect the patient's disability benefits and his job.

Claims Review Staff

For purpose of settling claims, insurance companies normally have their own claims reviewing staff responsible for the claims settlement. These personnel ensure all necessary documentation has been received and properly filed. They then review the material and, in cases where detailed technical advice is required will hire a medical or dental consultant to assist.

Once the claims review staff has reviewed the claim and is satisfied that the claim is valid they recommend payment as stipulated in the contract.

Investigators

In cases where the facts are uncertain or certain information is not presented, insurance companies will employ the service of investigators or obtain investigative consumer reports in order to obtain an independent opinion of the applicant's background, his occupation, social environment, home life and habits. The sources of information used by the investigators are friends, neighbours, business associates and fellow employees. The information obtained is used as a check on any information received and a source of new information which may be useful in determining risk and sometimes in settling claims.

Employers

Employers are cast in the role of intermediaries between the insurance companies and the insureds. The employers are usually charged with the task of obtaining the insurance for a group of employees. The employer must then communicate the terms of the policy to the employees to ensure the terms are understood. Employers play a major role in the settlement of claims for they file statements on behalf of the employees stating the details of the occurrence and in effect attesting to the validity of the claim. The employer also acts as a control agent in ensuring that when employees return to work they do not continue to collect benefits.

Occasionally, employers will enter into arrangements with the insurer under which the policyholder or employer, or a third party appointed by him and approved by the insurer, is responsible for the payment of short-term

income protection benefits during periods of sickness or disability and of medical and dental expenses. In these circumstances, the claim paying agency operates under the supervision of the insurance company's claims staff and is required to enter into a contract with the insurer, setting out the responsibilities which must be undertaken by the agency and the remuneration which they will receive.

CHAPTER 10

Other Accident and Sickness Insurance Plans

A. INTRODUCTION

In this chapter, matters concerning accidental death and dismemberment insurance and “other” forms of accident and sickness insurance coverages sold by insurance companies are reviewed briefly.

B. VOLUME OF BUSINESS

TABLE 5
ESTIMATED PREMIUMS EARNED IN
ONTARIO BY INSURANCE COMPANIES

ACCIDENTAL DEATH AND DISMEMBERMENT
AND OTHER ACCIDENT AND SICKNESS COVERAGES

For the Years Ended December 31

	<u>1979</u>	<u>1978</u>	<u>1977</u>	<u>1976</u>	<u>1975</u>
	(\$'000)	(\$'000)	(\$'000)	(\$'000)	(\$'000)
Accidental Death and Dismemberment					
Group	16,730	14,020	12,390	10,270	8,680
Individual	<u>20,670</u>	<u>18,480</u>	<u>14,290</u>	<u>12,600</u>	<u>8,940</u>
Total	<u>37,400</u>	<u>32,500</u>	<u>26,680</u>	<u>22,870</u>	<u>17,620</u>
Other types of Coverages					
Group	22,300	14,020	16,520	13,690	14,460
Individual	<u>5,510</u>	<u>5,100</u>	<u>3,570</u>	<u>2,800</u>	<u>1,790</u>
Total	<u>27,810</u>	<u>19,120</u>	<u>20,090</u>	<u>16,490</u>	<u>16,250</u>
Total Other Accident and Sickness Insurance Products					
Group	39,030	28,040	28,910	23,960	23,140
Individual	<u>26,180</u>	<u>23,580</u>	<u>17,860</u>	<u>15,400</u>	<u>10,730</u>
Total premiums earned	<u>65,210</u>	<u>51,620</u>	<u>46,770</u>	<u>39,360</u>	<u>33,870</u>

Note: This table has been reproduced from Table 1. The notes included with Table 1 also apply to this table.

Premiums earned from the sale of accidental death and dismemberment insurance policies have increased at an average annual rate of about 21% in the years 1976 to 1979. Premiums earned from other types of insurance products, such as travel insurance, occupational accidental death and dismemberment, student accident policies, and creditor's insurance, have increased at an average annual rate of 18% over this same period.

Together the total of these miscellaneous sickness and accident disability insurance products account for about 7% of the total premiums earned in 1979 by insurance companies and non-profit prepared medical care organizations for all disability financial protection coverages sold by them.

C. UNDERWRITING PROCEDURES

Accidental Death and Dismemberment

This product is usually sold to groups as part of a package of insurance. As such the underwriting concepts discussed earlier in this Part apply. The risk factors which tend to influence the issuance of accidental death and dismemberment insurance are: the industry in which the group is engaged and the ages of the employees. Some insurance companies also consider the proportion of each sex in the group as well.

Accidental death and dismemberment policies sold to individuals are occasionally sold as part of a life, and sickness or disability income protection package and as such are subject to the same underwriting and pricing procedures as apply to these products.

Accidental death and dismemberment policies are frequently sold as part of a travel insurance policy or as part of a motor club membership. When sold in this fashion the policy is available to the individual and there are no underwriting considerations other than those required for the particular activity.

Other Insurance Products

Occupational accidental death and dismemberment plans, group travel insurance, travel accident insurance for employees and student accident insurance plans are sold as a form of blanket insurance with the underwriting considerations being roughly the same as for groups except the members of the group are not generally known and as such do not affect the underwriting process.

Travel insurance, business overhead expense insurance and creditor's insurance is available to individuals. The underwriting considerations from the individual's point of view are few in number. The pricing of premiums is usually based upon the insurer's experience with that product.

D. CLAIMS HANDLING PROCEDURES

As with most groups, those purchasing accidental death and dismemberment and the other miscellaneous types of accident and sickness insurance follow a specified format for filing claims. In the event of a claim if an employee is involved, the employer notifies the insurer. A claim form is sent for completion to the employer, physician and, if applicable, the employee.

When the employee's coverage is verified, the policy provisions are examined to determine if the loss qualifies. If the claim is approved, a cheque is prepared for the insured in the amount specified by the contract.

When an employee is not involved individuals suffering a loss must usually notify the insurer within a certain time limit and must obtain a claim form from the insurer. The claim form is filled out and if necessary, a physician's statement is included. The claims reviewer verifies coverage and reviews the details of the claim. If more information is required the insurer will contact the insured to obtain the necessary information. Once coverage is verified a cheque is made payable to the insured or his beneficiary.

CHAPTER 11

The Marketing of Insurance Products

A. GROUP INSURANCE

Introduction

Most accident and sickness insurance coverage is sold to groups. Depending on the size of the group and the nature of the insurance package, coverage is sold by insurance companies through life insurance agents, casualty insurance agents, insurance brokers, insurance consultants and occasionally by employees of the insurance companies themselves. The non-profit prepaid medical care organizations use insurance brokers and consultants and their own staff to help sell their plans.

In this chapter, the marketing of group insurance to small and medium sized groups, large groups, association groups and blanket insurance by insurance companies is discussed in some detail with brief reference only to the marketing practices of the non-profit prepaid medical care organizations.

For the licensing year October 1, 1979 to September 30, 1980 the Office of the Superintendent of Insurance for the Province had issued licences to 1,325 agents to sell only accident and sickness insurance. There are five insurers who sponsored most of these agents.

- Combined Insurance Company of America;
- Constellation Assurance Company;
- Pan-American Family Insurance Corporation;
- The Paul Revere Life Insurance Company; and
- Pennsylvania Life Insurance Company.

In addition all licensed life insurance agents may sell accident and sickness insurance. There were 12,322 licences issued to life agents for the licensing year ended September 30, 1980.

Generally insurance companies sell their products in packages of insurance. The non-profit prepaid medical organizations are not able to market their products in this fashion. An insurance package might include some or all of a life insurance plan, sickness or disability income protection plan, an accidental death and dismemberment plan, a medical care plan and a dental plan. Many insurance companies insist that life and accidental death and dismemberment insurance be purchased by smaller groups before medical or dental care plans will be made available. Most of the benefits included in a package are consumer motivated. Benefit design has historically been controlled by the larger unions who try to obtain the best benefits for their members.

Small and Medium Sized Groups

The vast majority of group accident insurance issued to relatively small employers is sold by licenced life insurance agents. Most of this insurance is placed with the agent's sponsoring company, although there has been much more freedom to broker group business with other companies than is the case for individual life insurance.

Companies which sell their own group accident and sickness coverages employ their own sales staff to provide specialized assistance to the agent.

Large Groups

The majority of large group insurance cases are directed to insurance companies through or by insurance consultants. However, some insurers, in addition, are organized and prepared to market directly to employers.

Most consulting companies operate on a fee-for-service basis only and there is usually no connection with insurance companies. Their income is derived only from their clients. Benefit consulting includes the following basic functions:

- benefit plan design;
- financing of benefits;
- administration of benefit plans; and
- communication of benefit plans.

Most insurance companies dealing in large group insurance plans will assign experienced group representatives to work with a particular consulting firm in order to advise on policies and to induce the consultant to suggest insurance be placed with their company.

There are three basic levels of compensation paid to the marketers of group insurance; commission, fee with commission offset and plan fee.

Generally the sales process starts with an employer identifying a need for a group insurance policy or for a change in a present policy. In most cases, the employer, with a consultant, will draw up the plan specifications which will then be sent to selected carriers for review to decide if they are capable of and interested in meeting them and if so making a presentation to the employer and his consultant.

Association Groups

A few companies market accident and sickness insurance to individuals using the vehicle of Association Group Insurance. These are usually insurance programs sponsored by professional and trade associations for their members and sold to the membership by association solicitation. Typical examples of such associations would be the Institute of Chartered Accountants, The Law Society and the Association of Commercial Travellers.

Statutory reporting requirements are such that these sales are recorded as group sales. Further comment follows later about association groups in reference to the mass marketing of insurance.

-Blanket Insurance

Blanket insurance is defined in Section 241 of The Insurance Act as follows:

- “that class of group insurance that covers loss arising from specific hazards incident to or defined by reference to a particular activity or activities”.

Contracts of blanket insurance are exempted from section 247 of The Insurance Act which states that an insurer shall issue for delivery by the insured to each group person insured a certificate or other document in which are set forth among other matters the name of the insurer, the amount of insurance on the group person insured and the circumstances under which the insurance terminates. Usually, blanket insurance cannot meet these requirements since the person insured may not be known by name or is only known by title. Blanket insurance recognizes that certain groups such as groups of travellers or groups of persons with specific activities—students, boy scouts, athletes—are different than the conventional employer/employee groups or group of professionally trained persons such as doctors or lawyers. In blanket insurance contracts the total number of persons insured is usually known, not the individuals who make up the group.

Blanket insurance coverage can usually be provided immediately to a group of persons wishing to obtain accident or accident and sickness insurance for a trip in a hurry or in an emergency, a phone call to a broker or agent or directly to an insurance company is all that is required. Coverage can be obtained and confirmed immediately. In some cases, where the trip is only short the trip can be over before the group policy is issued. The persons may be known or unknown but a certificate or other document is not prepared as the insurance is no longer in force.

Blanket insurance was devised as a vehicle to permit exemption from some group insurance regulations or guidelines where such exemption is in the interest of the consumer.

B. INDIVIDUAL INSURANCE

Individual accident and sickness contracts represent a reducing share of the total accident and sickness insurance market. This is probably due to:

- the continued growth of the group insurance field, caused in part by the increasing importance of large firms in the national economy and the power of union bargaining;

- individual contracts represent a more difficult marketing challenge; and
- certain types of coverage require the spread of risk inherent in the group insurance approach in contrast to the potential for anti-selection that exists in the individually purchased and written contracts.

Life insurance companies marketing individual accident and sickness contracts, use their basic distribution and marketing systems for both lines and generally tie in sales of these products with sales of life insurance. At the other end of the spectrum are those companies that view individual accident and sickness contracts as a major product line on its own. This latter group of companies will tend to be more aggressive in the marketplace and will be willing to take greater risks than will most life companies.

Companies which specialize in the marketing of individual accident and sickness coverage rely on agents to sell the product whenever possible, even door-to-door. The policies are usually sold on a pre-issued basis, that is the policy is in force once the applicant signs the application form.

C. MASS MARKETING

Mass marketing is essentially a method of direct sale to the consumer without the aid of a licenced agent. The insurance is solicited through various mass advertising media such as the mail system and trade magazines. In the following summary some of the more common forms of mass marketing of accident and sickness insurance to individuals are discussed.

Association Groups

This is a recognized form of insurance marketed to members of trade, professional and other occupational groups. The insurance may be marketed to individual members or to the member firms. A member of the association is usually presented with an application form and description of coverage and invited to mail-in his application and cheque for the first premium.

Individual Direct-Mail

There is no sponsoring association and mailings are normally done to names and addresses appearing on lists which represent some definable segment of the insurance-buying public, for example, executives, salesmen or housewives.

Media Marketing

The buyer responds to an advertisement placed in one or more advertising media—radio, TV, newspaper, or magazine. The advertisement constitutes a direct invitation to contact the insurance company. Following

such contact the company will forward an application form to be returned with the first premium.

Credit Card Marketing

This method of marketing involves a direct-mail solicitation to holders of a credit card, sponsored by the card operators, with premiums charged to the policyholder's credit account. Premiums are occasionally "included" in the cost of the card or added to the charge for other services, such as tickets of travel charged to the card; in most cases the insurance plan requires separate application and a regular premium charge.

The sale of accident and sickness insurance to credit card holders is not new. However, it has increased rapidly in recent years with the proliferation of credit card consumerism in the 1970's, combined with a growing interest by credit card operators to increase the number of services offered to their customers. On January 1, 1976 the Association of Superintendents of Insurance of the Provinces of Canada introduced guidelines governing group accident insurance and group sickness insurance. These guidelines prescribed the types of groups to which a group accident and sickness insurance contract may be issued. Credit card groups were not recognized as permissible groups, although existing groups at December 31, 1975 were specifically exempted.

In the ensuing years since 1976, Ontario has been approached by a number of insurers interested in developing group accident and sickness insurance programs for credit card operators. While upholding the ruling of the Association of Superintendents to the effect that credit card organizations are not deemed to be proper groups, the Office of the Superintendent has nevertheless informed interested insurers that it would not object to the marketing of such plans on a group basis for the time being, provided that disclosure and documentation standards afforded the same degree of protection to credit card holders as is currently available in the case of individual policies.

A draft guideline governing credit card group accident and sickness insurance was developed by the Association of Superintendents of Insurance of the Province of Canada for discussion at their conference in Vancouver, in October, 1980. The guideline states the requirements which must be met in order to sell to credit card groups. The guideline applies to all forms of group accident and group sickness insurance excluding loss of income insurance due to sickness. Any insurer issuing a credit card group insurance contract must issue and deliver to each person insured a certificate setting forth certain information including: the insured's name, the amount of insurance purchased, circumstances of termination, name of insurer, claim making procedures, principal benefits and where more detailed information can be obtained if needed. The guideline also sets out details which must be included in the contract between the insurer and the credit card organization. The guidelines

also stipulate that the insurer or credit card issuer must make available an address and a toll-free telephone number should the insured wish to obtain further information. The anticipated loss ratio must be disclosed and all solicitations must observe the Guidelines respecting Mass Advertising. Discussions continue between the Superintendents and the insurers concerning the credit card guideline.

Rent-a-car Programs

With this method of mass merchandising, an accident insurance program is described in a brochure available at rental agencies. The aim of this type of insurance is to add the premium to the daily rate of the auto rental, if the renter wishes to take the insurance. This method of selling has caused concern to the Office of the Superintendent because there has been difficulty in enforcing guidelines aimed at regulating group contracts and disclosure in mass merchandising.

In form, the product is a group contract issued to a car rental agency which insures customers of the agency who have indicated purchase of insurance on the rental agreement. Benefits indicated as being provided are usually lump-sums payable on accidental death and dismemberment occurring during the period of rental plus reimbursement of medical expenses. In substance, the arrangement amounts to the mass merchandising of insurance paid for entirely by the renters at a cost of \$2 to \$5 a day. Generally, details of the coverage are contained in brochures available from the rental agency; however, the brochures do not conform to the Superintendents' Mass Merchandising Guidelines in that full disclosure is not made in the brochures highlighting the more important details in the contract of insurance.

Travel Agent Sales

A variety of different programs of insurance are available through travel agents, such as accidental death and dismemberment insurance, trip cancellation, baggage, and out-of-country medical expense. These programs are sold in conjunction with trips and tours, sometimes at individual option and sometimes built-in to the tour price.

Currently The Insurance Act exempts insurers issuing individual policies of accident insurance on a non-renewable basis for a term of six months or less or in relation to a ticket of travel, from printing in full the statutory conditions prescribed in section 249 of the Act, provided that the policy contains prescribed wording informing the insured that his policy is subject to such statutory conditions. In the case of group insurance, insurers providing group insurance of a non-renewable type issued for terms of six months or less are also exempted by The Insurance Act from the requirement of issuing for delivery to each group person insured a certificate or other document setting out certain information concerning his coverage. Otherwise

this business is subject to the same provisions that apply to other accident and sickness policies. The legislation is uniform in all the common law provinces of Canada.

The sharp increase in travel in the 1970's, has contributed to the growth of travel accident and sickness policies issued by travel agents. Problems of communication and the absence of adequate disclosure have contributed to a considerable increase in the number of complaints received by all Superintendents in Canada.

The Superintendents of Insurance have authorized a standing committee to draft guidelines to ensure that travellers buying this type of coverage have access to full information on the scope and extent of coverage they are purchasing, and that the insurer prepare instructional material on travel insurance and that such parties be required to be licensed or registered in their respective jurisdictions.

Airport Sales of Accident Insurance

Travel insurance marketed in airports is usually done through booths staffed by the insurance company. When the booths are not staffed machines are frequently available, effectively providing the purchaser the opportunity of buying travel insurance 24 hours a day.

Motor Clubs

Many motor clubs insure their members under a group personal accidental death and dismemberment insurance policy. The members of the club are usually insured as long as they remain members in good standing. Insurance usually begins the day of becoming a member and ceases the last day of membership. This type of insurance policy is usually available to all members of the club and their dependants, there are no pre-existing condition exclusions and all exclusions for specific circumstances are usually set out in the policy.

Benefits are normally payable in addition to any other coverage the insured may have.

Many auto clubs offer travel accident insurance to their members as well. This insurance covers accidental death and dismemberment during the term of the policy. There are no evidence requirements, however, the insurance is usually only available to members of the motor club.

D. NON-PROFIT PREPAID MEDICAL CARE ORGANIZATIONS

Generally these organizations employ a force of enrolment and service representatives. These representatives call directly on companies as regularly

as circumstances allow. In this way new groups are enrolled and existing coverage is reviewed.

Non-profit prepaid medical care organizations will co-operate with consultants and brokers who have been commissioned by clients to evaluate and advise upon the merits of alternative health plans. Any fees accruing to the intermediary for consultations are paid by the client company.

Certain non-profit prepaid medical care organizations will pay fees to any brokers or agents who may sell their product.

CHAPTER 12

Other Matters Relating to the Accident and Sickness Insurance Business

A. INTRODUCTION

There are a number of other matters pertaining to the accident and sickness insurance business not dealt with in preceding sections of this Part which are discussed in this chapter under the following headings:

- reserving practices;
- associations;
- self-insurance;
- confidentiality;
- statutory condition 4;
- discrimination in the accident and sickness insurance business;
- premium taxes;
- income taxes; and
- definitions.

B. RESERVING PRACTICES

Introduction

The Insurance Act of Ontario, in section 83, stipulates

“that all contracts of insurance issued by insurers shall include a reserve for all unmatured obligations guaranteed under the terms of its policies dependent on life, disability, sickness, accident or any other contingency or on term certain, and shall also include a reserve for profits ascertained and apportioned for future distribution.”

The Act then goes on to describe methods of computation of the reserves stipulating the rate of interest to be used, the tables of mortality to be used and the methods of valuation. The Insurance Act and regulations do not specify that morbidity tables must be used in the calculation of reserves. There have not been any morbidity studies made exclusively of the residents of Ontario nor have there been any such studies of the residents of Canada.

The various reserving practices followed by insurance companies transacting accident and sickness insurance are described briefly in the following two sections with reference to group insurance first and then individual insurance.

Reserving Practices for Group Insurance

There are two types of reserves with respect to group insurance costs, the first, a reserve for estimated incurred but not reported claims and the second, a

reserve established for future benefit payments on approved claims, notably future instalments on approved long-term disability claims.

Both reserves are included in the policy benefit charges. In large groups, benefit charges generally include the actual claims for the specific group, that is the groups are experience rated. For intermediate groups, benefit charges may be a weighted average of actual claims and average claims, depending on the size of the group and the type of insurance. This approach is designed to reflect the group's own experience for coverages where reasonable stability can be expected but to substitute average experience for coverages where fluctuations are the rule. Very small groups are always pooled, that is the average claims experience for all such groups is considered to be the benefit charge rather than the actual claims for the specific groups.

Since all claims incurred during a period are not necessarily reported during that period it is necessary to hold a reserve for the estimated incurred but not reported claims, and to reflect any changes in these reserves in the benefit charges for the accounting period. The size of these reserves depends on the average time taken by insureds to present their claims and also on the mechanics of the insurer's claims accounting system.

Benefit charges also reflect changes in reserves established for future benefit payments on approved claims. These reserves are based on actuarial tables which reflect interest and the rate of termination of benefits by recovery, expiry and death.

Analyses of disability income experience are complicated by the fact that claims costs represent the combination of:

- the probability that an employee will become disabled according to the terms of the contract and will so remain for the length of the waiting period (the rate of disablement); and
- the probability that such employee's disability will terminate either by death or recovery at some point prior to the expiry of the maximum benefit period (the termination rate).

In the case of short-term disability coverage, insurers generally use the claims experience to construct a claim continuance table which reflects the probability that a claim will continue for a given number of days. Obtaining sufficient data for long-term disability coverages is more difficult, however, because of the longer waiting periods as well as the considerably longer benefit periods. Furthermore, premium rates are differentiated by age which makes the problem of sufficient data even more critical since it theoretically creates a need for approximately 45 sub-cells of experience—one for each insurance age up to and including age 64. Finally, the rates of termination of claims vary not only according to the age at which disablement occurs but also according to the length of time that disability has persisted, thus creating a need in theory for an even larger number of experience sub-cells. As a result,

insurers customarily evaluate their experience in broad exposure classes in terms of modifications to published inter-company morbidity tables.

The cost of an insured employee benefit plan is the sum of benefit charges and retention. Retention represents the portion of the premium retained by the insurance company to provide for administration expenses, claim processing expenses, commissions, premium taxes, licenses, fees, and profit net of any interest credits. Premiums are set prospectively to cover expected benefit charges and retention. Thus, over the long run, for a very large group the cost of an employee benefit plan will be the actual claims for the employees plus the insurer's retention. For a very small group, the cost will reflect the insurer's average claims experience for all small groups, rather than the actual claims of the particular group, plus the insurer's retention.

Reserving Practices for Individual Insurance

Insurance companies must maintain three types of reserves for individual accident and sickness insurance policies.

The first type of reserve is a reserve for unearned premiums. Unearned premiums are the pro rata portion of premiums written in the current calendar year which will be used to provide coverage in the following calendar year. Written premiums are those premiums that would have been received if every premium were paid on its due date.

The second type of reserve held for individual accident and sickness policies is the Disabled Life Reserve which is equal to the present value of all benefits which can be anticipated to be paid during the continuance of disability of any life that is currently disabled. This reserve is generally calculated based on studies that have been performed by the Society of Actuaries. The last major study in this regard resulted in the publication of the 1964 Commissioner's Disability Table. However, many companies defer the use of these tables until the disability has existed for a certain period of months. Normally, during the first 12 months of disability, insurance companies use techniques that are designed to evaluate the remaining benefits on approved claims and to recognize incurred but not recorded claims and reported claims that have not yet been approved. With this information, tables are developed showing a certain percentage of the total amount ultimately paid on that claim. In addition to the reserve for future claim liabilities a reserve is usually established for loss adjustment expenses associated with the payment of those claims. This expense is usually expressed as a percentage of the amount paid in claims and the reserve is the same percentage of the claim liability reserve.

The third type of reserve held for individual accident and sickness policies is the Active Life Reserve. The calculation of this reserve is complex. For each year that a policy will be in force, the anticipated claim costs are

calculated first by multiplying the probability of a claim occurring in that year by the present value of a claim occurring at that age and benefit period. These claim costs are then discounted back to the date of issue using interest and mortality factors and the total then divided by the present value of an annuity of a dollar to obtain a net level premium. At each duration the present value of all future benefits is calculated and reduced by the present value of all future net level premiums. The result is adjusted to make allowance for the amortization of acquisition expenses over the life of the policy to determine the reserve at that duration.

C. ASSOCIATIONS

The major association representing the accident and sickness insurers in Canada is the Canadian Association of Accident and Sickness Insurers (CAASI). This association represents 85 insurance companies and fraternal societies having, according to CAASI, in excess of 90% of the total personal and accident and sickness insurance premium income received by all such insurers in Canada. Members of CAASI as at July 1, 1980 have been identified by an asterisk in appendices A and B.

The membership of the Association was comprised of life insurance, general insurance and specialty, accident and sickness only, insurance companies as well as fraternal benefit societies and insurers providing creditors' insurance.

The primary responsibilities of CAASI are to represent the industry in meetings with representatives of the federal and provincial governments, to make submissions to commissions or enquiries established to review matters related to the industry and to make recommendations about items in which the industry is concerned.

In addition to communication with public bodies, CAASI provides to its members, on a current basis, information relevant to matters bearing upon their day-to-day operations. The Association provides information concerning policy decisions, the introduction and enactment of federal and provincial legislation and regulations and other information bulletins.

The Association has developed a code of ethics, which was endorsed, in 1972, by the Association of Superintendents of Insurance of the Provinces of Canada. Membership in the Association is subject to continuing adherence to the code of ethics. A copy of the Association's code of ethics is included as Appendix F.

As of February 1, 1981 CAASI and The Canadian Life Insurance Association merged their operations to form the Canadian Life and Health Insurance Association (CLHIA) because most members carry on business in both the accident and life insurance fields.

The CLHIA meets on a regular basis with the Insurance Bureau of Canada to ensure that the entire industry is kept abreast of developments in its separate arms.

D. SELF-INSURANCE

Introduction

There has recently been a trend in the insurance market towards self-insurance programs whereby there is a transfer of the insurance risk from the insurance company to the plan sponsor. Certain people in the insurance industry predict that this transfer of risk under traditional group insurance programs will accelerate and eventually may result in necessary legislation and regulation to protect employees in much the same way as pension plan regulation has evolved.

Forms of Self-Insurance

The self-insurance programs take two forms; the first a form in which an employer enters into an agreement with an insurer under which the insurer provides the administrative expertise but is not at risk. This arrangement is known as Administrative Services Only (ASO); the second whereby an employer assumes both the risk and the administrative responsibilities.

An ASO contract with an insurer calls for the insurer to agree to administer the plan and settle claims. The money for benefit payments and operating costs remains under the control of the plan sponsor. Generally the benefits are funded through a Health and Welfare Trust Fund.

Some of the advantages of self-insuring as stated by various insurance consultants are:

- improved investment return on plan assets because reserve funds are managed by the plan sponsor;
- plan sponsors may use independent actuarial advice in establishing reserves; and
- plan operating costs are reduced by eliminating the provincial insurance premium tax.

Some of the concerns expressed by people involved in the accident and sickness insurance industry, stem from the fact that such arrangements of self-insurance are subject to neither solvency nor other regulatory requirements, causing a very real risk that employees may, in the event an employer experiences financial difficulty, find that expected benefits are not forthcoming when called for. Also, it has been stated that it would be undesirable to establish additional regulatory authority and requirements extending to self-insurance unless it were clearly established that a need existed to be fulfilled. Finally, concern has been expressed that should an ASO arrange-

ment become unworkable or be unable to fund the benefits as needed a shadow of doubt would be cast over the whole insurance industry.

Another relatively new form of self-insurance is currently available on a very restricted basis and is referred to as the “closed panel capitation system”. The system, for the moment, is mainly confined to dentists. In this system the contracting dentist assumes the financial risk by accepting compensation at a fixed per capita rate, usually on a monthly basis, in return for agreeing to provide specific, predetermined dental services as appropriate and necessary to eligible subscribers.

Under this system the dentist virtually insures the risk directly. He undertakes to provide certain services for a stipulated period of time to all eligible recipients in exchange for a certain periodic payment, regardless of utilization patterns. If fewer patients use the system than predicted the dentist will gain and, vice versa, the dentist works longer hours than expected if more services than predicted are demanded. Under OHIP some associations for medical services also operate on this system.

Third Party Administrators

Third party administrators (TPA) represent an alternative to the standard method of operating an employee benefit program. The principle upon which a TPA operates is that a given insurance carrier may be more competitive in one benefit area and less competitive in another. Using the traditional method of purchasing group insurance benefits, that is, one carrier insures the entire package, the consumer makes the choice based on the total package price and pays little, if any, attention to the component parts. The TPA agrees to act as a middle man between the employer and the various insurance companies. As the benefit quotes are on an individual component basis, the employer is free to choose the best, most benefit for least cost, carrier for each individual benefit.

The TPA provides the administrative services for an employees' benefit program which includes the breaking down of the premium received from the employer and the forwarding of it to the respective carriers. The TPA is responsible for enrolling and terminating employees in the correct coverages and all claims are sent to him which he in turn sends to the various carriers for payment.

E. CONFIDENTIALITY

The establishment and upkeep of complete and accurate records of subscribers, insureds, procedures and products is essential for billing groups, identifying participants, validating eligibility, pricing benefits and payment of claims and/or the reimbursement of subscribers. This information when augmented with utilization by age, gender and occupation provide subscriber/insured profiles, and group and individual consumption of benefits. To the

private sector, this material is essential to the proper conduct of an insurance plan for it provides the basis for experience rating, subscriber/insured rate adjustments and premium setting.

According to the insurance industry, the accident and sickness insurance industry has always recognized that it has an obligation to respect and safeguard the confidentiality of information it requires to administer its underwriting and claims processing practices. In order to ensure that confidentiality is maintained CAASI in co-operation with the CLIA has developed policy guidelines followed by the members of these associations. The thrust of these policy guidelines is that only proper and authorized means will be employed to collect information which is pertinent to the effective conduct of the insurance company's business. The guidelines ensure, where practicable, that information will be obtained directly from the individual; the individual will be notified should the information be collected from other sources; and pretext interviews and false and misleading practices will be avoided. The guidelines also state that the individual will be advised of the intended use, the nature and source of the information and have the opportunity to correct or clarify information retained by the company. Finally, the information will not be released without the individual's express written consent.

As is the case with the insurance companies and non-profit prepaid medical care organizations, many corporations have also adopted guidelines, although not formal, with respect to the confidentiality of employee information. Under the guidelines adopted by these corporations, employees will have the right to examine their personal file and to correct or amend their record to ensure accuracy. Employees will also be given control over the disclosure of these records so the information will not be used for purposes other than that for which it was provided. Record keeping is governed by explicit formal procedures and all information will be destroyed after a reasonable period of time.

F. STATUTORY CONDITION 4

The Canadian Association of Accident and Sickness Insurers and the Superintendent of Insurance for the Province of Ontario in their submissions to the Committee have stated their concern over statutory condition 4, reference Sections 249 and 250 of The Insurance Act, and its relation to the problem of over-insurance.

Under the provisions of the insurance acts of the common law provinces statutory condition 4 is required to appear or is deemed to be present in all individual policies providing income benefits. Statutory condition 4 states that

“where the benefits for loss of time payable hereunder, either alone or together with benefits for loss of time under another contract,

including a contract of group accident insurance or group sickness insurance or of both and a life insurance contract providing disability insurance, exceed the money value of the time of the person insured, the insurer is liable only for the proportion of the benefits for loss of time stated in this policy that the money value of the time of the person insured bears to the aggregate of the benefits for loss of time payable under all such contracts and the excess premium if any, paid by the insured shall be returned to him by the insurer.”

In the view of many, statutory condition 4 has the effect of creating situations in which over-insurance may develop. Many of the submissions made to the Committee included recommendations that statutory condition 4 be eliminated from The Insurance Act to permit the integration of individual policy benefits not only with those provided by other insurance policies but also with those available under public programs.

In his presentation to the Committee, Mr. Murray A. Thompson, QC, Ontario Superintendent of Insurance, devoted much of his attention to the problem of integration, that is the procedure by which benefits from several different policies of government and private benefit plans are co-ordinated. The Superintendent stated that under the present legislation there are no restrictions with respect to integration in a group accident and sickness plan but an individual policy may not be integrated with other government sponsored plans or support programs.

Insurers issuing individual income protection policies consider other sources of benefits in their calculations of benefits payable. However, there are several circumstances which can occur after issue which may give rise to over-insurance and which are beyond the control of the insurer. For example, definitions of disability under government pension plans are much more restrictive than those used by insurance companies. A claimant who is disabled under insurance industry standards may or may not qualify for benefits under Canada Pension Plan standards. There is a tendency to discount those benefits under government programs and consequently over-insurance under individual policies may arise when government program benefits are paid.

When a disability is work related and no offset has been included in the insurance policy there is a possibility of serious over-insurance through benefits received from Workmen's Compensation and those received from the insurance companies. Over-insurance can also occur whenever the disability results from an automobile accident. In Ontario the automobile benefit can be proportionately reduced when in combination with an individual accident and sickness contract it creates an over-insurance situation. On the other hand, however, statutory condition 4 does not appear to permit the disability insurer to reduce benefits, since the insurance contracts listed do not include an automobile insurance contract.

Existing group insurance and association plans are also recognized at the time of issue of an individual insurance plan, but new benefits issued or higher benefits affected subsequently can create over-insurance.

The insured is motivated to purchase integrated benefits by the potential for cost reduction if overlapping benefits are avoided.

The insurance industry has stated that there are two motives for inclusion of integration clauses: to offer a competitively priced product by eliminating over-lapping coverages; and, the insurance industry experience has shown that the incentive for claimants to return to work or complete a rehabilitation program is very much reduced if claimants are receiving total benefits close to or exceeding their pre-disability income.

The main problems with the integration of accident and sickness benefits occur in the area of income protection plans. Few problems arise over duplicate insurance of medical expenses because The Health Insurance Act prohibits the private insurance of services already insured under OHIP. There is one exception. No-fault automobile accident benefits coverage for medical expenses is permitted to duplicate OHIP insurance services thus enabling accident victims to be reimbursed for over-billings by opted-out physicians.

The integration problem with income protection payments is complicated by a number of factors. Firstly, there are many alternative sources of benefits making it difficult for the insured or the insurer to be aware of all possible overlaps in benefits or duplications in premiums. Secondly, there are differing philosophies of coverage with some insurers regarding entitlement to disability income as indemnity for loss of earnings and trying to define their position when a claim occurs as first or second payor up to a limit based on the lost earnings. Other insurers do not regard the benefit as indemnity for a loss but consider the benefit as absolutely payable on the occurrence of disability. The integration of benefits with government plans is complicated further by the fact that there is little evidence of co-ordination among various government plans and by the fact that individual policies cannot be directly integrated with government plans at the present time.

G. DISCRIMINATION IN THE ACCIDENT AND SICKNESS INSURANCE BUSINESS

The number of women in the market place as well as the number of women moving into middle and senior management has been increasing and is expected to continue to increase during the 1980's.

Ms. Elizabeth Sheehy of York University in a submission to the Committee regarding discrimination against women in accident and sickness insurance stated that women faced discrimination in three major areas:

— availability of disability insurance, on the following grounds

- women are seen as posing a grave moral hazard, in that they are perceived as secondary earners;
- women tend to work in non-insurable occupations, including housewives, servants and domestics; and
- women tend to be receiving salaries below the minimum insurable wage which inevitably serves to exclude a greater proportion of women than men from insurance.
- the setting of premiums, which she said are justified by questionable actuarial evidence; and
- the types and duration of benefits, stated by Ms. Sheehy as being only 2 years for sickness and 5 years for accident, and that “women are unable to collect benefits for their most common disability—pregnancy.”

The insurance industry has expressed its concern over the allegation that it is discriminating against women in the market place. As far as maternity benefits are concerned the insurance industry states that it is normally a conscious decision to raise a family and it can be argued that an insurable risk is not involved, though loss of income may be. Complications of pregnancy however, not being anticipated, can legitimately be regarded as such a risk.

H. PREMIUM TAXES

Insurance companies licensed under The Insurance Act are subject to a 2% premium tax on premiums collected.

The non-profit prepaid medical care organizations are not governed by The Insurance Act. As such, these organizations are not subject to the 2% premium tax. In Canada, Quebec is the only province in which a premium tax is levied on a Blue Cross plan.

The existence of the 2% premium tax has caused much concern in both the non-profit prepaid medical care organizations and the insurance companies licensed under The Insurance Act. From the point of view of the non-profit prepaid medical care organizations it is felt that should they be brought under the control of The Insurance Act they would immediately be subject to the premium tax. They argue that this would be socially unjustifiable as organizations providing benefits on a non-profit basis return almost 95¢ of every premium dollar to the subscribers in the form of benefits and the imposition of a 2% premium tax would be a direct additional cost to the subscribers.

Insurers licenced under The Insurance Act feel that organizations governed by The Prepaid Medical and Hospital Services Act enjoy an unjustified competitive advantage. The insurance industry does not believe that the premium tax should be applicable but rather recommends the

elimination of the premium tax. In the alternative they suggest all be included for uniformity.

The insurance industry recommends the elimination of the premium tax on the basis that it discriminates against residents who wish voluntarily to make provision for income protection during accident and sickness and therefore reduce the provincial assistance in times of distress. The industry states that these residents should be given every incentive to obtain adequate protection and not be taxed for doing so. The insurance industry also believes that the premium tax is one of the main reasons for the development of “Administrative Services Only” plans where the employer carries the insurance risk and the insurance company merely provides the administrative services. A major incentive to adopting this type of plan appears to be the avoidance of the insurance premium tax.

In 1979, the premium tax collected from the companies operating under The Insurance Act on the accident and sickness insurance portion of their business was approximately \$12,500,000. If premium tax had been applied to the premiums written by the non-profit prepaid medical care organizations in that year the amount would have been about \$4,000,000.

I. INCOME TAX

A brief review of the income tax treatment with regard to premiums paid and benefits received is set out in this section.

Benefits paid out of an insured sickness, accident, disability or income maintenance plan prior to 1972 were tax free to the recipient. Since the employer's premiums could be deducted from the employer's taxable income there was a tax escape of significance, especially to higher paid employees. Commencing with the 1972 tax year, benefits became taxable when received by the employee, if any portion of the premium was paid by an employer. There were also certain transition provisions applicable to plans that were in force before June 19, 1971.

When an employer does not have an insured or funded disability income plan but simply continues wage or salary payments for a period when an employee is absent, the employer may charge such payments as operating expense for tax purposes and the employees must pay tax on payments received just as though they were ordinary wages or salary.

In the case of an insured disability plan the following is the tax situation:

- the employer may deduct the premiums or contributions to the plan;
- the employer's contributions to the plan are not added to the employee's income for tax purposes;
- if the plan is an employee-pay-all type plan the employees may not deduct their contributions from their incomes for tax purposes;

- benefits received by employees to which the employer has contributed are taxable; however, the employee may deduct from the payments received by him the aggregate of contributions made by him to the plan after the year 1967; and
- benefits received from an employee-pay-all plan are tax free.

In summary, benefits are deemed taxable income in the hands of the recipient provided the employer pays any portion of the cost of those benefits. At the time benefits are paid, income taxes may be withheld at source and remitted to the government; however, income tax withholding is not required in Ontario but is available upon request for certain policyholders. At the end of each calendar year the insurer must prepare T-4A slips indicating the amount of benefits paid during the year and must arrange to have these slips delivered to the insured plan member through the policyholder.

J. DEFINITIONS

Section 11 The Insurance Act Ontario defines “accident insurance” as follows:

“accident insurance” means insurance by which the insurer undertakes, otherwise than incidentally to some other class of insurance defined by or under this Act, to pay insurance money in the event of accident to the person or persons insured, but does not include insurance by which the insurer undertakes to pay insurance money both in the event of death by accident and in the event of death from any other cause.

The Act then goes on to define “sickness insurance” as follows:

“sickness insurance” means insurance by which the insurer undertakes to pay insurance money in the event of sickness of the person or persons insured, but does not include disability insurance.

The interpretation section of The Insurance Act defines disability insurance as follows:

“disability insurance” means insurance undertaken by an insurer as part of a contract of life insurance whereby the insurer undertakes to pay insurance money or to provide other benefits in the event that the person whose life is insured becomes disabled as a result of bodily injury or disease.

It is interesting to note that there is no definition of disability in The Insurance Act which might be a part of any life contract.

CHAPTER 13

Legislation and Supervision

A. LEGISLATION AND SUPERVISION OF ACCIDENT AND SICKNESS INSURANCE

Introduction

Both insurance companies and non-profit prepaid medical care organizations provide financial protection to residents of Ontario at times of sickness and accident. Insurers providing these coverages come under the jurisdiction of The Insurance Act. Non-profit prepaid medical care organizations, on the other hand, are governed by The Prepaid Hospital and Medical Services Act. Both acts provide that the Superintendent of Insurance of the province will carry out a supervisory role concerning the operations and affairs of the providers.

The insurance companies and the non-profits must also abide by the provisions of The Health Insurance Act which prohibits the sale of coverage against certain health care costs which are covered by that act and provided by OHIP.

In its Fourth Report, the Committee commented on the legislation and regulation of the life insurance industry in Canada and Ontario. Much of that legislation also applies to the accident and sickness insurance industry and as such will not be repeated here. Interested readers should refer to pages 49 to 56 of the Fourth Report.

Brief reference is made here only to the special features of legislation and regulations as they apply to the providers of accident and sickness coverages. These matters are dealt with under the following headings:

- history of accident and sickness insurance regulation; and
- Association of Superintendents of Insurance of the Provinces of Canada.

History of Accident and Sickness Insurance Regulation

In his presentation to the Committee the Provincial Superintendent outlined the history of Part VII of The Insurance Act respecting accident and sickness insurance. Some excerpts follow:

“Part VII of The Insurance Act, the history of which was detailed in the fourth report on the insurance industry, now embraces legislation that is uniform in all the provinces of Canada, in the Yukon and in the Northwest Territories, with the exception of the Province of Quebec.

As early as 1914, the Provincial Superintendents of Insurance had considered the question of adopting uniform statutory conditions for contracts of accident and sickness insurance. While work was still in progress at the provincial superintendents' level, the federal authorities enacted, as section 134, of The Insurance Act (Dominion), (1917, c. 29), a series of terms and conditions which had to be included in all contracts of accident and sickness insurance by all federally registered insurers. Based on the belief that contract law is within the exclusive jurisdiction of the provinces and supported by case law (*Citizens Insurance Company V. Parsons*, (1881) 7 A.C. 96) and by an explicit recognition of the pre-eminence of provincial legislation in section 134(4) of The Insurance Act (Dominion), the provincial superintendents continued their work with a view to developing uniform accident and sickness insurance legislation. In 1921 a model Act was adopted by the Association of Superintendents of Insurance of the Provinces of Canada and recommended to the provinces for enactment. The uniform Part was first enacted by Ontario in 1922 and within the next two years in all the other common law provinces. Newfoundland enacted the uniform Part in 1957. This uniform Part was revised and re-enacted in 1924, in 1958 and in 1969. The federal legislation was repealed in 1932 and never re-enacted.

The 1969 revision came into force in Ontario by proclamation on October 1, 1970. It embodies the recommendations for uniform legislation made by the Association of Superintendents at its 1967 annual Conference. The revised part mostly responded to concerns about the absence of co-ordination between parallel enactments under the life and the accident and sickness insurance parts, by introducing important changes in the language of certain provisions that correspond now, to a large degree, to comparable provisions in the life part and by enacting provisions of an intrinsic value to accident and sickness insurance that already existed in the life part. The main changes embodied in the present uniform part were revised definitions, improvements in the substantive law on group insurance and extensive revisions, including new sections in the areas dealing with the rights of beneficiaries. Some minor changes were also introduced for the purpose of updating The Insurance Act to reflect practices that had evolved since the last revision, such as the introduction of the concept of "blanket insurance".

Two significant amendments to Part VII were enacted by Ontario in 1973.

The first amendment is embodied in section 245a of The Insurance Act. This section renders null and void any confinement clause related to the payment of disability benefits. It applied to contracts issued after November 2, 1973. Prior to this enactment a limited number of

carriers had been marketing a specialty product, at a substantially reduced premium, relating disability to confinement, particularly confinement at home on doctor's orders. . . .

The second amendment is embodied in section 246a of The Insurance Act. Under this section insurers are required to continue paying disability benefits arising from a disability that occurred before the termination of a group policy, notwithstanding the termination of such policy. The liability of the carrier embraces accidental death or dismemberment benefits resulting from such prior disability. This section also protects the right of eligibility to coverage under a replacing group policy of a person insured under the old group policy, by preventing absence under disability from disqualifying a member under the replacing contract. Provided that a new (replacing) group policy is issued within 31 days from the termination of the old policy, persons insured under the old contract become automatically covered under the replacing contract, so long as they belong to a class of insureds that is eligible for coverage under the new policy. Enactment of this section was prompted by a number of cases brought to the attention of the Office of the Superintendent where insurers had discontinued paying benefits to a person disabled by reason of termination of the group insurance contract, in accordance with a contractual provision that allowed such discontinuance. . . .”

Association of Superintendents of Insurance of the Provinces of Canada

The potential for havoc is apparent within the accident and sickness insurance industry if each of the provincial jurisdictions developed its own legislation without at least some consistency across the country. The provincial authorities recognizing the problem organized The Association of Superintendents of Insurance of the Provinces of Canada in 1917 with the purpose of “promoting uniformity in insurance laws”.

The Association of Superintendents of Insurance have in recent years expanded their activities by issuing a series of guidelines dealing with various matters concerning the conduct of the insurance business. These guidelines have no force in law but are prepared by the Association to indicate to the industry how it is expected to act regarding the matters covered in the Guidelines. Insurers do not have to comply to the guidelines, however, they generally do. The non-profit prepaid medical care organizations generally feel no compunction to conform to the guidelines.

The guidelines affecting both individual and group accident and sickness insurance are aimed at improving current standards of disclosure, enhancing the rights of group persons insured and containing the premium cost of certain plans to the consumer, by monitoring the loss ratio of such plans.

At present there are four guidelines in force covering the accident and sickness insurance industry concerning:

- mass advertising of life, accident and sickness insurance;
- group accident insurance and group sickness insurance;
- disclosure relative to accident and sickness insurance; and
- disclosure of benefits, limitations and exclusions in individual policies of accident and sickness insurance.

In addition the provincial Superintendents are considering draft guidelines concerning travel accident and sickness insurance and credit card groups respectively. Copies of these six guidelines are included in Appendix G.

Travel Accident and Sickness

Travel accident and sickness insurance policies marketed by travel agencies are issued on a non-renewable basis for a term of six months or less. These policies are exempted from having to present, in full, the statutory conditions prescribed in section 249 of The Insurance Act, providing the policy contains information stating that the policy is subject to such statutory conditions.

The guidelines under consideration would be designed to ensure that purchasers of this type of coverage have full access to information regarding the scope and extent of coverage; instructional material must be prepared for intermediaries; and, all intermediaries be licensed or registered in their respective jurisdictions.

Credit Card Groups

Credit card groups are not permissible groups according to the guidelines governing group accident and sickness issued in 1976. Those credit card groups which were in existence prior to that date were exempted.

The draft guidelines currently being reviewed are aimed at enhancing the disclosure and documentation requirements and include the requirement that insurance premiums under group credit card plans be given priority over other amounts due when applying payments by a credit card holder. The Superintendents are also considering in the draft guideline an extended period of grace during which insurance remains in force and a right to convert to an individual plan providing similar benefits in the event of termination of the plan for any reason.

B. THE SUPERINTENDENT'S OFFICE

Introduction

In his presentation to the Committee the Ontario Superintendent expanded on the activities of his department and the manner in which he and

his staff administered certain provisions of The Insurance Act and the Regulations thereunder as they relate to accident and sickness insurance. Among other matters he provided details concerning:

- the licensing of agents;
- regulation of accident and sickness contracts; and
- the handling of complaints.

The Licensing of Agents

For the licensing year, which ran from October 1, 1979 to September 30, 1980, the Office of the Superintendent of Insurance issued 1,325 individual accident and sickness licences to agents. Further, it is to be noted that all life licences issued to agents by the Office of the Superintendent also include accident and sickness insurance. Therefore, an agent licensed to sell life insurance is also licensed to sell accident and sickness insurance. For the 1980 licensing year, the Superintendent issued 12,322 life licences to agents.

Regulations of Accident and Sickness Contracts

The Insurance Act requires all insurers transacting the business of accident and sickness insurance to file, with their application for initial licensing, copies of all policy forms and forms of application for insurance proposed to be used in Ontario. There is no statutory requirement for filing new contract material devised for use by an insurer, after receiving its licence in Ontario. However, the Superintendent has the right to ask an insurer to file any contract material used by it in Ontario, at any time. Upon the report of the Superintendent, the Minister may, if he concurs, order the Superintendent to prohibit the insurer from using any such material that is, in the opinion of the Superintendent unfair, fraudulent, or not in the public interest. The Minister must give the insurer concerned the benefit of a hearing prior to reaching a decision.

In some instances, insurers writing accident and sickness insurance have voluntarily filed contract material for a review, particularly in cases where a new product constituted a material and innovative departure from existing programs. This has been particularly prevalent in the field of accident and sickness insurance, the breadth and scope of which has been substantially affected by the introduction of government sponsored medicare plans since the early 1960's. Over the years, the Office of the Superintendent of Insurance has endeavoured to review and comment upon most of these filings. As no approval of any of this material is required, the review has been selective, with emphasis either on certain types of products, which have caused concern because of their nature and the methods used for their marketing, or on new products to assess their potential effects on the consumer.

In addition to the above statutory filing, accident and sickness insurers are required to file material under a guideline respecting mass advertising of life insurance and under guidelines on credit group insurance.

Handling of Complaints

The Office of the Superintendent handles complaints through its policy services section. In the year ended March 31, 1980 the section handled 1,600 written complaints from consumers, approximately 5% of complaints, that is 80, related to accident and sickness insurance.

The Superintendent identified the major areas of concern reflected in the complaints as follows:

- “— In long-term income protection claims, complaints often arise when payments to the insured are terminated on the basis of the opinion of the company physician only.
- In employer-employee group accident and sickness insurance, we often receive complaints that an employer has either neglected or failed for other reasons to make a proper claim within the contractually stipulated time, generally within one to six months from the commencement of the disability.
- The use of outside investigators by the insurance company to check out the disability status of the claimant.”

PART III

ACCIDENT AND SICKNESS PREVENTION AND REHABILITATION

CHAPTER 14

An Overview of the Concerns with Accident and Sickness Prevention and Rehabilitation

Those concerned with matters relating to accident and sickness protection appear to be unanimous that there are three important, and most will say equally important, aspects of the subject. Protection against the costs of medical care and for income maintenance during disability is the most obvious and well publicized. Matters relating to this aspect, the responses presently available in Ontario and, in particular, the role of insurers and non-profit prepaid medical care organizations were discussed in Parts I and II of this Report. A successful accident and sickness protection system must also have two other broad objectives—those relating to “safety and prevention” and “rehabilitation” with aims in the first case, to promote general safety, to prevent accidents and minimize injuries and in the second, to promote prompt, effective rehabilitation.

The matters of safety and prevention and rehabilitation and the programs in place in Ontario regarding each are the subject of this Part including the role of insurers and non-profit prepaid medical care organizations in these areas.

As the various programs are described, it is apparent that governments at all levels, the private sector and concerned voluntary groups and citizens are not insensitive to the needs and problems of both prevention and rehabilitation. However, it also is obvious that there are almost a mind-boggling proliferation of programs each designed to respond to particular perceived areas of needs.

In Chapter 15, preventive programs are discussed including factors that contribute to, or act to prevent, the occurrence of a particular sickness, accident, or disability. Programs of risk avoidance and preventive action are important because they are an investment offering the potential for future savings in health care costs and related support programs. Preventive programs are beneficial not only to individuals and their families, but also to society. Ideally, the environment, at work, at home, at other places, and while travelling, would be safe for everyone.

The situation concerning the requirements of those who have had the misfortune to suffer disabilities and need rehabilitation assistance is reviewed in Chapter 16.

CHAPTER 15

Preventive Programs

A. INTRODUCTION

There are natural events such as earthquakes, floods, lightning and other “acts of God” which can cause injury, disability and death and against which preventive programs are either not possible or frequently ineffective. On the other hand, preventive programs are appropriate and more effective against some other hazards capable of causing injury, disability, or death. The key to such programs lies in education, engineering, and enforcement.

B. THE NEED FOR SAFETY AND PREVENTIVE PROGRAMS

The aim of any preventive program is to reduce the risk of sickness or accident by providing information about, by compensating for or by correcting the contributing factors.

As regards accidents, preventive programs may reduce risks by compensating for or correcting in the individual such factors as:

- person’s age and training;
- any physical defects or disease;
- unusual individual susceptibility;
- personal and social adjustments;
- fatigue;
- emotional states—anger or depression;
- alcohol; and
- drugs or medication.

in the work place, such factors as:

- poor design, construction, materials, vehicles and structures;
- lighting or lack thereof;
- noise;
- variables of atmosphere and climate; and
- toxic agents.

in the social environment, such factors as:

- living patterns; and
- the role of recreational activities.

Effective preventive programs may also reduce the incidence of diseases and man-made calamities, consider:

- a fit and healthy person is less likely to become sick;
- proper nourishment and recreation contribute to a person's good health;
- good dental hygiene reduces the incidence of tooth decay;
- a study conducted for the Ontario Ministry of Culture and Recreation established that if all Ontario adults aged 20 to 69 years were at least at an average physical fitness level, OHIP claims could be reduced by \$31 million;
- use of automobile seat belts reduces the risk of injuries in an accident;
- federal legislation requires new cars to be equipped with seat belts;
- lower speed limits and effective enforcement reduce the risks of injuries in traffic accidents;
- safety education and training programs may reduce accidents that would otherwise result from clumsiness, confusion, momentary lack of attention, or lack of experience or common sense;
- well designed machines of suitable materials and workmanship minimize risks to the operators and maintenance people at plant, office, or home;
- plant layout and operating practices can be designed to minimize risks to employees or visitors;
- the introduction or spread of technology, for example, the chain saw, may lead to different types of accidents and injuries, or to different groups of victims;
- effective testing of products/medications minimizes risks such as the thalidomide deformities; and
- responsible waste disposal and land use practices minimize the potential for a "Love Canal".

These examples demonstrate the range of preventive actions by:

- personal actions for oneself and one's family;
- organization actions;
- employer actions;
- manufacturer actions; and
- government actions.

Whether the aim of a preventive program is to lower the risks of accident or to reduce the need for medical or dental care, in order to be effective, programs must be interlinked and have the objective of providing maximum coverage for persons and families with a minimum of duplication. Under any circumstance, such programs require active participation and/or effective enforcement to minimize sickness, accident, and disability. Success of most programs however, is mainly dependent on individual responsibility.

C. THE PRESENT SAFETY AND PREVENTIVE PROGRAMS IN ONTARIO

In response to the needs for safety and preventive programs, a vast array of lifestyle, fitness and safety information and other schemes have been developed and set in place for the benefit of the citizens of Ontario dealing, among other matters, with:

- alcohol and drug abuse;
- stress management;
- smoking cessation;
- fitness and exercise;
- back pain;
- nutrition and weight control;
- driver education;
- defensive driving;
- safety awareness;
- block parents;
- accident research;
- occupational safety;
- hearing protecting;
- safety inspection and enforcement for such items as elevating devices, pressure vessels and electrical appliance standards;
- water safety;
- transportation safety, both road and off-road;
- road safety engineering;
- pure food and drug regulations;
- first aid; and
- fire safety, suppression and rescue.

The approaches and facilities used in these programs cover the full range of media communication, including:

- meetings;
- conferences;
- seminars;
- instruction in class or at site e.g. driving skid school;
- films e.g. fitness, fire alarm procedures;
- posters i.e. do's and don'ts for riding school buses;
- television, e.g. WCB work safely spots; national driving test;
- newspapers/magazines/booklets/leaflets, both advertisements and publications;
- displays e.g. Blinky the traffic safety car;
- pennants/stickers i.e. Elmer the Safety Elephant;
- individual action i.e. block parent program;
- promotions e.g. safe boating week;
- awards e.g. for days of accident free operation, or for persons saved from injury by safety gear;

- incentives e.g. reduced life insurance premiums for abstainers and for non-smokers; demerit assessments by WCB for employers with poorer than average safety records; and
- inspection, prosecution and fines.

Many organizations are involved in various aspects of these lifestyle, fitness, accident prevention and safety programs. Some organizations operate with a service orientation, others concentrate on research. In Ontario, these organizations include:

- Federal government;
- Provincial government;
- Canada Safety Council;
- Ontario Safety League;
- Safety associations e.g., Industrial Accident Prevention Association;
- Workmen's Compensation Board;
- Insurance companies;
- Non-profit prepaid medical care organizations;
- Royal Lifesaving Society;
- Red Cross;
- YMCA;
- St. John Ambulance;
- Municipal recreation councils;
- District health councils;
- Employers in business and industry;
- Private consultants;
- Addiction Research Foundation;
- Alcoholics Anonymous;
- Local lung association; and
- Local sport medicine clinics.

Under today's social and political environment no government, business, industry, private foundation or agency can hope to deal singlehandedly with the multi-faceted nature of the issues involved.

Each participant, however, makes demands on the limited sources of funds available. In many cases, as a result, many feel that deserving programs, often ones particularly important to them, are underfunded. The problem is complicated by the fact that the success of any prevention program rests in something that did not happen—accidents and disabilities did not occur; disease did not break out; or an elevator did not crash. The effectiveness of programs is difficult to measure. Success produces little publicity, failure gets media attention.

At the present time, no viable co-ordinating mechanisms are in place which would, in a formal way, bring together all of the parties who could gain from a concerted effort in the fitness, safety and accident prevention field.

D. THE ROLE OF INSURERS AND NON-PROFIT PREPAID MEDICAL CARE ORGANIZATIONS IN SAFETY AND PREVENTIVE PROGRAMS

In general, it can be said that the insurance industry takes an active role in the fields of safety and accident prevention.

The general insurance industry through the Insurance Bureau of Canada (IBC) and the Insurer's Advisory Organization (IAO) have developed and actively promoted sophisticated campaigns related to such matters as safe driving habits and driver education; fire prevention and safety in the home; fire prevention in multi-family dwellings and in plants; and, safe operating practices in plant and warehouse operations. They make extensive use of films, brochures, T.V., newspapers and magazines—all with the aim of reaching as wide an audience as practical.

Likewise the Canadian Life Insurance Association (CLIA); CAASI and the non-profit prepaid medical care organizations have prepared booklets and various forms of advertisements for media use as part of health education programs all designed to inform the public of the risks of smoking, drugs, alcohol and stress and the advantages of fitness and moderation.

CHAPTER 16

Rehabilitation

A. INTRODUCTION

In spite of any risk avoidance or preventive actions that may have been taken, it is an unfortunate fact that people will continue to be afflicted as a result of sickness, accidents and disability. As a consequence, the third aspect of a comprehensive disability program, rehabilitation, will always be extremely important.

In concept, an effective rehabilitation system requires co-ordinating people, facilities, aids, training, attitudes and opportunities in a complete program designed to provide both the care and atmosphere conducive to providing the sick, injured or disabled with the best chance to live as full and fruitful lives as practicable. The active co-operation of the patients, the patients' families, the medical profession, social workers and voluntary and government agencies are all required to make a satisfactory system of rehabilitation. To be most effective, rehabilitation should start from the time recovery commences from sickness or accident and finish when the patient has resumed a satisfying role in society.

B. THE AIMS OF AND NEEDS FOR REHABILITATION

The first aims of rehabilitation are medical and designed to speed the healing process, to eliminate physical disability, if possible, to reduce or alleviate disability to the greatest extent possible, and to prevent regression or further disability. The second aim of rehabilitation programs is more vocational in nature with the purpose of assisting patients to:

- maintain their present abilities and functions;
- retrain in their old activities, or train in new activities;
- train/retrain those with residual physical disability to live and work within the limits of their disability, but to the extent of their capabilities;
- restore a worker to employment, where possible, in order to minimize compensation and disability payments; and
- achieve a satisfactory level of physical, cultural, social and recreational activities.

Persons in need of rehabilitation represent a broad spectrum of society, and may require rehabilitation in some or all of a number of ways.

Occupational Rehabilitation

Occupational rehabilitation applies to the task of training or retraining for employment members of the work force who have become disabled. It

covers those who are able to return to their former jobs on a full or part time basis, and those whose disability requires a change of occupation. It is important for those recovering from temporary disability, and more important for those with permanent disability.

Occupational or vocational training also applies to the task of educating and training disabled children, with the expectation that those who are able will be trained to enter into the workforce.

Recreation

Recreation is an important aspect of living for the able-bodied, and can be even more important for those whose living opportunities have been limited by mental or physical handicap. Accordingly, rehabilitation programs for the disabled need to consider recreation and the enjoyment of leisure hours. Recreation may include:

- physical activities: outdoor activities-sports, camping, and indoor activities-gymnastics, table tennis, dancing;
- cultural activities: music, drama, art, handicrafts, literature;
- social activities: public and private social evenings and entertainment, picnics and excursions.

Rehabilitation counselling and follow-up work should be concerned not only with the employment objective but also with placement of the disabled person into suitable community recreational situations.

Other Rehabilitation Needs

Other rehabilitation requirements, such as moving to premises more suited to the disability, making structural changes to a dwelling such as wider doorways, installation of an elevator, relocation of facilities to the ground floor or providing hand controls for a car, concern a disabled person's life at home and his or her facility to travel for personal or business purposes.

Further, while not related to the rehabilitation of a specific disabled person, parks, gardens, buildings, theatres, auditoria, and sporting facilities, should be physically accessible to the handicapped, and community facilities for sport and recreation should cater to the handicapped as well as to the able-bodied.

C. RESPONSE TO THE REQUIREMENTS FOR REHABILITATION SERVICES

The need for rehabilitation has not been ignored in Ontario. There are some well organized rehabilitation resources and there are also a variety of services, programs and plans designed to assist the sick and disabled to rehabilitate and adjust to their incapacities. In this section rehabilitation

services available to the sick and disabled in Ontario and certain related matters are discussed briefly under a number of headings:

- eligible workers;
- eligible veterans;
- insured persons;
- other programs
 - for children
 - for adults
 - co-ordinating government programs;
- employment after sickness or accident.

It is particularly noteworthy in the following review that only in the cases of eligible workers and veterans are comprehensive rehabilitation programs in place. To the extent that other long-term sick and disabled people are covered by income protection contracts with insurance companies *and* the insurer involved is interested, they too may have rehabilitation services provided to them. In all other cases, the sick and disabled requiring rehabilitation must rely either on voluntary or government agencies for rehabilitation assistance.

A disabled person may therefore become eligible for one rehabilitation program if the cause of his or her disability was work related but another entirely different program, possibly several programs, if the disability occurs elsewhere. Further, a youngster will be eligible for one program until the age of 18 and then be transferred to another different and separately administered program upon reaching that age.

Rehabilitation and Eligible Workers

Workers covered by workers' compensation injured on the job have available to them extensive services provided by the Workmen's Compensation Board to assist their rehabilitation. The Board in its explanation of its operations stated that it recognizes the importance of effective co-ordination of medical care and rehabilitation and that it has designed its rehabilitation programs starting almost immediately after an accident occurs and ending only when the injured worker is effectively placed in employment.

In its presentation to the Committee it went on to explain, skilled personnel are employed by the Board and assigned to each worker's case to assist the treating doctor in completing appropriate medical rehabilitation programs. Medical rehabilitation is recognized as one part of a continuing rehabilitation process including, where necessary, vocational rehabilitation and job placement. Workmen's Compensation, therefore, attempts to ensure close links between the two stages of rehabilitation including contact between an injured worker and a vocational rehabilitation counsellor early in the treatment process. The Vocational Rehabilitation Department of the Board operates under no financial or time limit on its vocational rehabilitation

services to provide vocational and social counselling; job placement counselling; vocational appraisal; and trade skills and vocational training.

The Board also maintains continuing contact with those who cannot return to work because of the severity of their injuries. Workmen's Compensation has an on-going responsibility for medical care related to compensation injury and for prostheses and other necessary aids, including home adaption.

Rehabilitation and Eligible Veterans

Federal government policy is that every entitled Canadian veteran will receive the best quality of medical care and treatment. The eligible veteran like the injured worker, can look to a single authority to provide for a variety of needs, or to refer him or her to other appropriate sources of assistance.

In the past, medical and rehabilitation care of the veteran was provided principally in separate veterans' hospitals in most provinces. More recently, in order to maintain the position of veterans' hospitals as active treatment hospitals while the average age of veterans increases, Veterans Canada has been progressively transferring the facilities to the community at large, while retaining priority beds and over-all responsibility for the care of veterans.

In addition to hospital care, the following services, among others, are available to sick and disabled veterans: medical and dental treatment, prosthetic services, domiciliary care, vocational retraining and counselling.

Rehabilitation and Insured Persons

The sick and injured covered during their periods of incapacity for income protection under contracts issued by either general or life insurance companies may have available rehabilitation assistance.

A CAASI brief noted in commentary on the industry's involvement in rehabilitation—

“the expansion in the number of disability claims—led to an active involvement in rehabilitation for a number of reasons. First, from a business point of view, a small investment in rehabilitation is an effective cost control measure when it produces a large overall saving through the re-employment of a claimant. Second, insurance companies, as good corporate citizens with an alert sense of social responsibility, have a genuine concern for the overall well-being of disabled claimants. Thirdly, in the last quarter century government-provided social insurance programs in Canada have taken over large segments of the private accident and sickness insurance field; hospital and medical programs are prime examples. Companies are convinced that only by providing responsible and adequate services can they prevent similar encroachments in the income maintenance field.”

In addition, when insured disabled persons return to active participation in the work force, as one insurer commented

“it reduces our liability and enables us to pass on to insured individuals the benefits of a lower cost of Long Term Disability Benefits.”

On the other hand, the Canadian Council on Social Development commented in its report “A Hit-and-Miss Affair” in reference to insurance companies and their rehabilitation programs

“The process is not always smooth. At times it is seen as an attempt at claims avoidance rather than a helpful service.”

Efforts have been made to co-ordinate the industry's efforts regarding rehabilitation through an Insurance-Rehabilitation Liaison Committee. In a presentation to the World Congress of Rehabilitation International in June 1980 Mr. R. R. Rowlands of CAASI explained the origin and objectives of the Committee as follows:

“In September 1970, Dr. Keith Armstrong, then National Executive Director of the Canadian Rehabilitation Council for the Disabled, called together representatives of some twelve insurance companies to exchange information and explore possible means of assisting companies in their desire to rehabilitate certain of their claimants who were disabled. Before the end of the year a liaison committee with the insurance industry was established within CRCD and the first formal meeting of what was to become the Insurance-Rehabilitation Liaison Committee took place. It now functions independently as a nation voluntary organization whose purpose is to encourage and facilitate the flow of information between insurance and rehabilitation personnel and promote the development of rehabilitation techniques, particularly as they apply to disabled beneficiaries under private insurance programs. The Committee's membership comprises representatives appointed by the Canadian Association of Accident and Sickness Insurers, The Canadian Life Insurance Association, Insurance Bureau of Canada and the Canadian Rehabilitation Council for the Disabled. Each Association appoints three committee members except CRCD, which appoints four. The Committee's objectives are to coordinate activities surrounding rehabilitation when insurance is involved; to support educational programs for the general public, employers, employees, the medical and legal professions, insurance and rehabilitation personnel, emphasizing the importance of early recognition of opportunities for rehabilitation of the disabled; to develop communication channels throughout the insurance industry and allied areas for the dissemination of rehabilitation information; to promote understanding of the economics of rehabilitation, its financial implications and benefits; to make available, where possible, consulting

and other services for the benefit and assistance of persons involved in management of disability cases; and to develop public relations programs in support of the rehabilitation concept. Activities arranged and sponsored by the Committee are self-supporting financially but research projects requiring funding are referred to the member's parent associations for support."

In the decade of its existence, the Committee has held seminars and courses covering rehabilitation topics such as:

- the philosophy of rehabilitation;
- the rehabilitation process;
- the impact of disability, its physical and psychological effects;
- treatment methods;
- vocational assessment and counselling;
- the role of voluntary services and associations for the disabled;
- financial protection under various government programs;
- case histories;
- social problems;
- rehabilitation centres;
- cost benefits of rehabilitation;
- community vocational resources;
- company program planning and organization;
- psychological aspects of working in rehabilitation;
- placement problems; and
- problem cases.

While some efforts are made to co-ordinate insurers practices regarding rehabilitation services, little if any attempt has been made at communication, let alone at developing joint programs, on rehabilitation matters between insurers and the Workmen's Compensation Board.

Further, while individual insurance companies may be involved in rehabilitation, the rehabilitation services available to insured persons vary among plans and among companies. Some companies are more actively involved than others.

Some companies treat the identification of their claimants' potential for rehabilitation and the means of developing that potential as a claims function. Claims personnel visit disabled policyholders to assess their condition and, if possible, help them in their rehabilitation. In this approach, rehabilitation is considered part of the claims process and a cost control measure.

Several companies employ staff rehabilitation counsellors who are not directly involved with the claims department. Company objectives are the same, both with respect to economic feasibility and rehabilitation of the insured person. Case management techniques, however, may vary as a result of the specialist's training and background. Other companies engage the

services of private consultants for recommendations on rehabilitation feasibility, possible vocational goals and suitable programs.

Where community programs are not available, some insurance companies will assist with retraining, job restructuring, adaption of premises, or other measures to enable a disabled person to return to work. Some insurance companies may look favourably on employers prepared to co-operate by taking their workers back; and may offer premium discounts. Some employers may choose insurers offering group plans with rehabilitation provisions.

Training and Rehabilitation Programs for Children

The medical care rehabilitation requirements of disabled children, most of whom are disabled from birth, are provided by children's and general hospitals, special health care clinics, treatment and rehabilitation centres, public health nursing and a number of departments and agencies of the government. Further, volunteer organizations raise funds for special aids and equipment needed by disabled children. Various service agencies provide services related to particular disabilities. The Ontario Society for Crippled Children operates programs and on occasion acts in a co-ordinating capacity. Treatment often includes identification of the disability, treatment on an in-patient and out-patient basis and continuous monitoring.

In addition, training disabled children is a vital part of their "rehabilitation" involving the education system, pre-school programs, the residential unit and recreational facilities and arrangements. The meshing of medical care and training may include therapy, special education and psychological services.

When a disabled child becomes too old for children's benefits he or she must transfer to the programs available for adults. In some cases services available to children are not available to adults.

Ontario Government Programs for Children

Various government ministries provide rehabilitation programs and services for both children and adults. Co-ordination of government rehabilitation services, and the services for adults are described later; the services for children are outlined below:

- Handicapped Children's Allowances include funds for eligible families to cover expenses, including assistive devices for severely disabled children being cared for at home.
- The Province licenses and funds children's mental health centres which provide services for emotionally disturbed children and youths.

- The Province shares the cost of 14 Crippled Children's Treatment Centres. Daily programs involving counselling, schooling, speech and occupational therapy, and physiotherapy are available in out-patient centres to assist children with birth defects and neuromuscular conditions to develop to their maximum potential.
- The Province provides residential programs for disturbed and developmentally handicapped children.
- The Province licenses and supervises day nursery centres for developmentally handicapped children from ages 2 to 18; centres for physically disabled children, and integrated centres for both normal and disabled children.
- The Province delivers mental retardation programs and services to the developmentally handicapped and their families through government-operated facilities, community/board operated facilities, and diagnostic and assessment centres. Included are a comprehensive range of treatment and training programs and services, in facilities for persons with developmental disabilities, such as: assessment and diagnostic services to the community at large, crisis intervention, parent relief, residential care, nursing and medical care, treatment programs, behaviour modification programs, and other specialized services.

The Province also offers programs of instruction for parents and staff in the care and training of the mentally retarded. It conducts and supports highly specialized programs of research and education into the causes, prevention and treatment of mental retardation, intended to reduce its severity and incidence. And it provides recreational and social activities as well as a full range of consulting and advisory services to support the daily operations and management of facilities for the mentally retarded.

- Education of the physically disabled child is a high priority of the government. Many of these children receive their education with their age peers in regular programs. Bill 82, an amendment to the Education Act, requires all school boards in the Province to provide special education services for exceptional children. All such school aged children enrolled in the publicly supported school system, including those with physical and learning disabilities, will be offered a range of services. Twenty-one school boards are currently participating in a pilot project to determine the cost, number of programs and the staff necessary. Boards will be required to develop plans of implementation for their programs with full implementation of the bill due by 1985.

There will be an expansion of existing programs to include more students, with benefits affecting both the children themselves as well

as public attitudes towards disabled pupils. In order to improve the accessibility to schools and programs, the following are provided:

- special transportation allowances for adapted vehicles and individualized transportation;
 - capital grants allowances where existing facilities are altered to accommodate physically disabled students;
 - in the construction of new buildings, provision for the physically disabled is required; and
 - personalized special education equipment grants are provided where the equipment will maximize the students' opportunities to learn, included are adapted desks, wheelchairs, hearing and vision devices.
- Governments operate special schools and centres with on and off campus training for the disabled, and for teachers of the disabled. There are:
- three provincial schools for the hearing impaired;
 - a provincial school for the blind;
 - eleven provincial development centres' schools;
 - local schools for the trainable mentally retarded;
 - local special education programs for the visually and hearing handicapped; and
 - school aged children who are homebound or hospitalized due to temporary physical disabilities or illness other than a physical disability have access to instruction which is provided by local school boards; teachers provide instruction in the home or hospital on a regular basis for a minimum of 180 minutes a week; this program may be augmented by correspondence courses offered by the Ministry of Education; students who are resident in facilities for care and treatment and are unable to attend local schools, may receive their instruction through an agreement between a local school board and the facility.

Rehabilitation Programs for Adults

Ontario rehabilitation services beyond those mentioned previously for eligible workers, eligible veterans, insured persons and disabled children, are discussed in this section. Coverage applies to the community at large, including non-eligible veterans, workers who are disabled by non-work related accidents or illnesses, and children when they reach age 18.

The basic concern of these programs is with work and the ability to earn an income. Such programs are not new. Since 1953, there has been a federal co-ordinator in the Department of Labour who works with the provinces under agreement to provide financial assistance for the development of vocational rehabilitation programs for those disabled other than at work.

Under current legislation the federal government shares equally with the provinces the cost of providing and co-ordinating

“any process of restoration, training and employment placement, including services related thereto, the object of which is to enable a person to become capable of pursuing regularly, a substantially gainful occupation”.

Since the objective of the Act is “to enable a person to become capable of pursuing regularly a substantially gainful occupation”, children, the aged, and working-age adults for whom a return to the labor force is unlikely are excluded. On the other hand, Ontario has extended its services to housewives. A child who leaves school early must wait until the age of eligibility is reached. While, in theory, the program is open to all of working age, older disabled persons may be regarded as poor prospects for rehabilitation, and may be forced to wait out the time until they qualify for retirement pensions.

Ontario Government Programs for Adults

The various rehabilitation programs provided for adults by the government of Ontario through various departments and agencies are summarized below:

- Under the Work Incentive Program, (WIN) qualifying disabled persons who wish to be self supporting, receive cash benefits, for up to two years of full time employment. An allowance is provided for back-to-work expenses, and family medical coverage continues while the person is involved in the program.
- Vocational rehabilitation services are provided, including counseling, psychological testing, specialized assessment and training services, restoration and job placement services for physically, mentally or emotionally disabled persons who are vocationally handicapped. The goal is to develop, restore or improve the working capacity of the individual to enable them to obtain employment. This includes employment in the open labour market, in-home or sheltered employment, or self-employment.
- Simulated working conditions are available to disabled persons in workshops operated by voluntary organizations and subsidized by the Province.
- Grants are available to voluntary organizations providing rehabilitation services to disability groups with highly specialized needs. Included in these groups are persons with hearing or sight impairment, those who are mentally retarded, and those with spinal cord injuries.
- General and Special Rehabilitation Hospitals, and Special Rehabilitation Units of public and regional hospitals offer co-ordinated

programs of rehabilitation and physical medicine to persons recovering from injuries, disabilities or acute cases of illness.

- Adult Rehabilitation Centres provide co-ordinated rehabilitation programs on an out-patient basis to assist persons with severe disabilities who no longer need in-patient care to recover functional ability. Therapy, treatment, prevocational assessment, and vocational counselling are provided.
- A full-time consultant on leisure activities for the disabled is available to provide assistance and support to agencies and organizations that wish to develop opportunities for meaningful community involvement for disabled persons.

Co-ordination of Ontario Government Rehabilitation Programs

The government of Ontario has many rehabilitation activities for children and adults. Co-ordination of these activities rests with a Coordinator of Rehabilitation Services and an interministry team representing 12 ministries and agencies—the Ministries of Community and Social Services, Culture and Recreation, Labour, Correctional Services, Transportation and Communications, Housing, Education, Health, Revenue, and Consumer and Commercial Relations; the Civil Service Commission; and the Workmen's Compensation Board.

The functions of the team are to:

- co-ordinate provincial planning for the delivery of rehabilitation services;
- co-ordinate the development of policy affecting rehabilitation services;
- function as the government point of reference for the cases of individuals whose rehabilitation needs are not being met, recommendations being made to the concerned ministries on how to resolve the difficulties being faced by these individuals;
- recommend to individual ministries or to the Cabinet Committee on Social Development, as appropriate, changes in policy which will resolve generally the difficulties demonstrated in individual cases;
- recommend to the concerned ministries or the Cabinet Committee on Social Development ways in which the integration of rehabilitation services at the community level can be improved;
- identify gaps and duplications in programs and to recommend to individual ministries and/or the Cabinet Committee on Social Development how these may be rectified;
- review legislation affecting rehabilitation and to recommend changes to individual ministries and to the Cabinet Committee on Social Development as appropriate;

- encourage the development and use of evaluative methods to measure the outcomes and effectiveness of existing programs;
- make recommendations to the Cabinet Committee on Social Development for the improvement of employment possibilities for the disabled;
- make recommendations to the Cabinet Committee on Social Development regarding priorities for cutbacks, extensions and modifications in services;
- make recommendations to the Cabinet Committee on Social Development regarding priorities for allocation and utilization of available research dollars;
- collect and analyze data in a systematic fashion; and
- compile and share information on program operations.

Employment after Sickness or Accident

Where full recovery is made after sickness or accident, an employee or a self-employed person usually will resume his or her previous occupation. Where accident or sickness results in disability, the person's employment prospects may be quite different. For example, loss of a finger might not affect a truck driver's return to work; it might prevent an office worker resuming work as a typist. A rehabilitation program would be expected to prepare such a person for other duties. Ideally, rehabilitation includes medical treatment, vocational rehabilitation, and the placement in employment of suitably qualified disabled people. This latter step is difficult to achieve.

Open employment

Some disabled persons will be able to obtain full, part-time, or seasonal work in the open job market, depending on the person's education and experience, the requirements of the job, accessibility of transportation, the attitude of the employer and/or the union toward disabled persons, the emphasis of various employment placement services, and so forth. Unlike some other countries, such as Britain, West Germany, France, Italy, The Netherlands, and Japan, no Canadian jurisdiction has a system of mandatory quotas of disabled persons that each employer of a designated size must employ.

Sheltered employment

Other disabled persons will be able to obtain work specifically for the disabled in "sheltered" employment. Sheltered workshops may fulfil various roles:

- as a final phase in rehabilitation; that is, a pre-placement work situation preparatory to employment on the open market;
- as a source of employment in areas without employment opportunities for disabled people; and
- as a means of employment for those for whom employment on the open market is not possible.

PART IV

SOME ALTERNATIVES TO THE PRESENT SYSTEM

CHAPTER 17

An Overview

A. INTRODUCTION

In previous Parts of this Report the Committee has reviewed the present “system” in Ontario of financial protection available to the citizens of the Province during periods of disability and the role of the insurance industry and the non-profit prepaid medical plans in that system. In this Part alternatives to the present system are discussed.

In Chapter 17, some suggestions brought to the attention of the Committee by witnesses appearing during its hearings in mid-1980 are summarized. In Chapter 18, certain aspects of the programs either in place or proposed in some other countries are reviewed. Then in Chapter 19 proposals and studies in the provinces of Saskatchewan and Manitoba relative to alternatives to the present system are covered briefly.

It will become obvious as one reads this Part that the problems of providing adequate financial protection to the public during periods of disability are more or less universal. It will also become apparent that while many throughout the world are grappling with the problem, finding solutions is not easy.

In the remainder of this chapter some of the suggestions for improving or for revamping the present system presented to the Committee during its hearings by the following are summarized:

- The Superintendent of Insurance for the Province of Ontario.
- The Canadian Association of Accident and Sickness Insurers (CAS-SI).
- Professor Reuben Hasson
- Professor Edward Belobaba
- The Canadian Union of Public Employees (CUPE)

B. THE SUPERINTENDENT OF INSURANCE FOR THE PROVINCE OF ONTARIO

In his presentation to the Committee the Superintendent of Insurance made a number of suggestions for improvements in the present system of accident and sickness insurance as it operates at present in Ontario.

The main problem the Superintendent identified related to the co-ordination of private sector accident and sickness benefits with the wide range of government plans, particularly in the disability income field. While acknowledging that part of this problem may be overcome by regulating the insurance industry more closely he expressed the view that much more important was

good co-ordination of all government plans. In his view, if this was done there would be much less need for complex regulations of the private insurance sector.

Integration of benefits in the context of accident and sickness insurance is the procedure by which benefits from several different policies or government or private benefit plans are co-ordinated. Under present legislation there are no restrictions with respect to integration in a group accident and sickness plan but an individual policy may not be integrated with other government sponsored plans or support programs.

Problems rarely arise over duplicate insurance of medical expenses but the integration problems with disability income payments are especially complicated by a number of factors. Underlying these problems is the lack of co-ordination among the various government plans. Problems arise as the definition of disability, eligibility for coverage, covered earnings, maximum benefits, tax status of benefits among other matters, are not uniform from one government plan to another. The Superintendent went on to comment "as employers or insurers try to integrate their plan with all other government plans, complication abounds. In this complex and unco-ordinated field of disability income, an average consumer would have great difficulty in determining his need for disability income protection and then selecting a policy with appropriate integration clauses from an insurer".

The Superintendent in a later portion of his presentation indicated that in his view another major problem is the taxation of disability income benefits. He noted "some benefits are taxable while others are not. Marginal tax rates being what they are, this makes a significant difference in the net benefits being made available to the disabled person".

C. CANADIAN ASSOCIATION OF ACCIDENT AND SICKNESS INSURERS (CAASI)

In its two presentations and submissions to the Committee, CAASI indicated:

"One of the perhaps valid criticisms of the performance of the private accident and sickness industry is the relatively poor market penetration that is achieved among those sectors of the population which are either self-employed or are not members of large employee groups. Although it is true that there are insurers willing to cover this market, the fact that so many companies do not participate in it, coupled with the conventional wisdom that these contracts are sold rather than purchased, means that there are many individuals who possess the financial resources to purchase individual accident and sickness insurance contracts but who may not have been solicited or have chosen not to purchase coverage."

CAASI then went on to explain that the industry's penetration of the higher income self-employed, farmers and independent businessmen is very high. However, at the other end of the economic scale, smaller contractors, owners of smaller farms and operators of small businesses are less frequently insured partly due to the fact that they have lower incomes and partly due to the fact that they are "higher risk" in the industry's view. It is not unusual, for example for individuals to be accepted as standard risks for life insurance contracts but rated sub-standard or denied coverage in the case of disability income insurance. In the course of its submissions CAASI dealt with a number of matters that in their opinion could be done to improve the present accident and sickness income protection system without changing its basic nature. CAASI then commented on two alternative co-operative approaches, it had proposed to the governments of Saskatchewan and Manitoba in the event either of them adopted an universal disability income replacement program.

These observations are summarized below:

Increasing the Number of Individuals with Accident and Sickness Insurance Protection

CAASI acknowledged that the insurance industry itself has room for improvement in its performance in penetrating the market for accident and sickness insurance. Large employer/employee groups are well served. Further, it felt that the industry had done a good job with the high income self-employed. More recently, with the use of the association group approach, the industry had been able to improve its penetration of small firms in some industries, including the self-employed in those industries. Beyond this, CAASI admitted much remained to be done by the industry and it needed to take positive steps to improve its performance in the individual market place, noting, at the same time, that the industry will never have success among those who do not have the means to purchase coverage. Thus, there will always be a need for governments to play a part.

CAASI added that they felt strongly governments should lend every encouragement to those who wish to be self-sufficient even when accident and sickness strikes. The association therefore suggested that there should be income tax exemptions and provincial tax credits for premiums paid, with appropriate limits on such incentives. CAASI observed:

"Incentives of the kind suggested would greatly assist the industry toward reaching the objective of a much expanded individual market by creating a climate in which insurers would be encouraged to fully participate in individual lines and in which the public would be more receptive to marketing efforts."

Integration of Health Benefits

CAASI discussed in some detail its perspective of a major problem currently facing the medical care system in Ontario and Canada that of:

“The growing gap between the level of fees that the Provinces are willing to recognize in their medical care insurance plans and the level of income that many doctors believe to be consistent with the declared principle of reasonable compensation.”

The brief commented on the fact that it is difficult to determine whether “opting-out” has resulted in any significant impairment of the “reasonable access” principle. It went on to suggest that “the availability of group practice, under which doctors would be compensated on a salary basis might clarify the issue considerably.” As has been noted the Ministry of Health recognizing this potential has established some arrangements with organizations of this kind.

CAASI expressed the opinion that “extra billing” should continue to be permitted but that if the perception by doctors is that compensation from the public plan is adequate only a minority of doctors would resort to extra billing. The association suggested that the government should review the situation and reach compromise arrangements with the doctors possibly through the use of suitable provincial tax credits within the framework of the existing income tax system.

Another alternative would be to permit complete “opting-out” of the public plan by doctors. This type of provision exists in the Quebec Health Insurance Plan and is also a feature of the National Health Plan in the United Kingdom. CAASI therefore suggested that “an in-depth evaluation of the roles played by non-participating physicians in the Quebec and U.K. systems be made to determine whether or not there are any aspects of them which could be desirable throughout Canada.”

CAASI then took the opportunity to urge that the provinces which currently prohibit private insurance plans from including benefits for all medical fees including the out-of-pocket expenses individuals incur as a result of “extra billing” or “opting-out” be abolished since they do not in any significant way affect the frequency of these practices and simply inconvenience the patient. CAASI therefore recommended that the present prohibitions be amended “so as to prohibit duplications only of the amounts paid under the provincial plan, rather than the ‘cost of insured services’ ”.

Integration of Disability Income Benefits

Insurers provide short and long-term benefits under income replacement or wage loss protection policies for those disabled as a result of suffering an accident or sickness. There are many public programs that also provide such benefits. Inherent in this mix of programs is the possibility of over-insurance.

CAASI has recommended to the Association of Superintendents of Insurance of the Provinces of Canada that Statutory Condition 4 be eliminated from the insurance acts of the common law provinces and thereby permit the integration of individual policy benefits not only with those of other insurers but with benefits available from public plans. Elimination of Statutory Condition 4, reference sections 249 and 250 of The Insurance Act, would permit insurers to establish the nature of any integration provisions to be written into a contract. A more detailed discussion of Statutory Condition 4 appears in Chapter 12 of this Report.

Universal Disability Income Replacement Program

For a number of years, both the governments of Saskatchewan and Manitoba have been giving detailed consideration to the implementation of more comprehensive systems of financial protection for the disabled of their provinces. In this connection, CAASI has been involved in discussions with representatives of those provinces and has made specific proposals for their consideration. CAASI summarized its ideas in a submission to the government of Saskatchewan dated February 1, 1978.

In the introduction to its submission, CAASI in discussing the purpose of its brief, as detailing the association's recommendations with respect to income replacement insurance for those who become disabled while insured, indicated that their recommended course of action was referred to as "the voluntary approach". This approach envisages a co-operative effort on the part of the private insurance industry "to ensure that any income earner . . . wishing to avail himself of disability income replacement coverage could do so regardless of that person's state of health or occupation." A maximum premium would be established for each \$100 of monthly income benefit expressed as a percentage of earnings up to a defined limit.

CAASI acknowledged that many believe that disability income replacement insurance programs should be mandatory believing that it is inequitable to allow some who suffer income losses due to disability to look to the state for support while others pay to provide for themselves. In recognition of this point of view CAASI outlined in its brief "the compulsory approach" that it felt would be appropriate if it was decided to require that disability income replacement schemes would have mandatory provisions.

Finally, in its introduction CAASI noted that the Saskatchewan Committee had recommended a plan which would in effect provide first-day coverage. In CAASI's view virtually all income earners are either adequately covered for short-term disabilities or have ready access to such coverage, therefore, their proposals in the submission dealt only with long-term benefits.

More particular aspects of CAASI's proposals under the "voluntary approach" and "compulsory approach" follow:

The Voluntary Approach

The features of this recommended approach are:

1. The private insurance companies would provide a standard plan to all who applied for it. There would be an individual standard contract and a group standard contract and in each case the basic plan would have an established maximum rate per \$100 of monthly benefits for all who chose to seek the coverage.
2. The essential concept of the plan would be replacement of earned income.
3. The plan would be available to all who sought it with no exclusions for pre-existing health conditions.
4. The only eligibility requirements would be "those necessary to prevent abuse of the plan". CAASI suggest that this would include coverage be limited to those actively-at-work and that eligibility would require a specified weekly minimum number of hours be regularly worked.
5. Insurers would create a pooling mechanism whereby participating insurers would share the risk of insuring high risk individuals and groups. It would be proposed that the pool would operate on a breakeven basis after allowing for "justifiable costs of administration and distribution."
6. Legislation would be required that all insurers who wish to continue to market disability income insurance in the province would be required to participate in the entire program as proposed. Insurers would undertake to make the standard plan available at rates not to exceed the established maximum. Insurers would also agree to participate in the pooling mechanism.

If an insurer chose not to participate in the program, it is suggested that the legislation forbid such insurers to provide basic income replacement programs in the province. Insurers would be permitted to operate only on a group basis or only on an individual basis if they wished but would be required to participate in the pooling mechanism for the portion of the business in which they were involved.

7. Both insured and self-insured income replacement plans providing benefits equal to or better than those of the standard plan would be allowed.
8. Self-insurers would be required to share in the pooling arrangements.

9. Benefit payments under the program would commence after the 17th week of disability as defined and continue until the claimant recovered, died or attained age 65.
10. In order to ensure continuity of coverage for those changing employment a 30-day extension of group coverage would apply with coverage available to the employee through the group plan of his new employer immediately active work commenced.
11. The maximum insurable earnings level under the program would be set at a relatively low level. In the proposal to the government of Saskatchewan, it was indicated that this level should be \$10,000 which compared with the average industrial wage at that time in the province of \$13,000 per year.
12. The government of Saskatchewan had suggested that the benefits under the universal program would be non-taxable. CAASI in its submission suggested that there were administrative difficulties in relating income replacement benefits to the insured's after-tax pay and therefore recommended a benefit level of:
 - 70% of the gross annual earned income assuming that the benefit is taxable, or
 - 60% of the insured's gross annual income assuming that the benefit is non-taxable.
13. A limitation should be established so that the combined income from all private and public income protection programs would not exceed 70% of net take-home pay. In arriving at this conclusion, CAASI had considered:
 - the question of affordability,
 - a level of benefit geared to avoid over-insurance,
 - a level of benefit that would not act as a disincentive to return to work.
14. Benefits under the Canada Pension Plan and the plan as proposed would be integrated with the benefit level determined when the two benefits become concurrently payable. Any subsequent cost of living adjustments in CPP benefits would be passed on to the disabled person.
15. Subject to the prescribed maximum insurable earnings figure and the cost of administration and distribution, the level of benefit and premium for each individual would be determined;
 - for persons covered under the group standard contract, premiums and benefits would be established and adjusted based on changes in the individual's respective level of earnings;

- for persons covered under an individual standard contract, premiums and benefits would be established and adjusted periodically on a basis to be determined and subject to application being made.

A maximum rate per \$100 of monthly benefit would be established annually based upon the financial experience under the plan.

The Compulsory Approach

CAASI indicated that they were not in agreement with the concept of making any accident and sickness benefit program compulsory. However, if this was the decision of the government, CAASI proposed that the insurance industry administer the plan.

CAASI then went on to indicate that they would anticipate that the nature of the proposed coverage under the compulsory approach would be identical in all respects to that proposed under the voluntary approach. More specifically, private insurers would provide a standard plan to all income earners regardless of the state of their health or their occupation and the premium for this standard plan would not exceed an established maximum. There would be stipulated eligibility requirements to include for example an “actively-at-work” clause and requiring a specified weekly minimum number of hours of work on a regular basis. As with the voluntary approach a pooling mechanism for high risks would be established among the insurers. All private insurers offering income replacement insurance and all self-insurers would be required to share in the pooling operation.

CAASI would anticipate that individuals or employer groups could obtain and insurers would provide plans that exceeded the minimum requirements of the standard plans. Insurers providing these would be free to determine premiums for these extra benefits as they saw fit.

CAASI's Summary of the Two Approaches

CAASI concluded its submission to the government of Saskatchewan as follows:

“Both approaches we have put forward have distinct advantages:

- (1) They would make both sickness and accident income protection insurance available to all income earners.
- (2) They would allow employers and unions freedom of choice and freedom to bargain on a number of important matters such as level of benefit and the length of waiting period providing these features were better than those of the standard plan.
- (3) They would permit the forces of competition to operate in the marketplace and would utilize the expertise of those already trained

to administer private accident and sickness income replacement plans.

- (4) Insurers would maintain and indeed extend existing in-house facilities which work toward the rehabilitation of disabled claimants. A standing insurance industry-rehabilitation community liaison committee would continue its efforts to encourage and promote effective rehabilitation programs.
- (5) They would not involve the creation of a costly administrative structure which to a large extent would be duplicating work already done by others.
- (6) They would allow employees and self-employed persons to continue to enjoy existing accident and sickness benefits beyond those prescribed by the standard plan. As well, these proposals preserve the right of the individual to purchase supplementary protection or to obtain alternate plans which provide more appropriate benefits geared to the individual or to the employed groups' perceived needs.
- (7) Either approach would be actuarially sound and meet the legislative requirements of Canadian insurance laws."

D. A PUBLIC INSURANCE COMPENSATION SCHEME FOR CANADA OR ONTARIO

Several submissions were made to the Committee proposing a public insurance compensation scheme for Canada or failing that for the Province of Ontario alone. Among those making this proposal were Professor Reuben A. Hasson, Professor of Law, Osgoode Hall Law School, York University, Edward P. Belobaba, Associate Professor and Associate Dean, Osgoode Hall Law School, York University, and the Canadian Union of Public Employees (CUPE) supported by the Ontario Federation of Labour (OFL). A brief summary of their proposals follow:

Professor Hasson

Professor Hasson proposes that disability insurance be taken out of the hands of private insurers and be run by a Crown corporation. The proposal would involve the extension of workers' compensation to all victims of accident and sickness and would cover self-employed as well as employees. There would be a substantially higher ceiling than the present level of \$18,000. The suggestion was made the ceiling should be \$40,000 to \$50,000 with those earning more than that amount given the option of obtaining supplementary coverage.

The suggested universal plan would contemplate automatic inflation proofing. There would be separate schemes for victims of road accidents, funded by drivers of motor vehicles. In addition, there would be a residual

scheme which would cover all other disabilities; i.e., other than those caused at work or on the roads. This residual plan would cover all earners and be extended to cover homemakers and children. This portion of the scheme would be financed out of general government revenues.

Professor Belobaba

In his presentation before the Committee, Professor Belobaba did not make a proposal as such for a universal accident compensation scheme. Rather, he discussed his observations and research that lead him to the conclusion that a comprehensive accident compensation plan is inevitable in Canada either for the country as a whole or in each of the ten provinces. Professor Belobaba's conclusions were based on the work he had been doing for the federal Department of Consumer and Corporate Affairs and the report of his research and conclusions, which is yet to be released to the public, entitled "Product Liability and Personal Injury Compensation in Canada: Towards Integration and Rationalization".

The inevitability of a universal accident compensation scheme is in Professor Belobaba's view necessary to replace the "hodge-podge" approach to personal injury and disability in Canada today with an integrated more manageable and more effective loss reparation system. While he admits that there may be some dissatisfaction with present social insurance plans in operation today that there is general acknowledgement of the fundamental worth and validity of such schemes as workers' compensation and provincial health insurance. The trends in most of the provinces of Canada to more social insurance planning has been accelerating in recent years. In other countries of the world as well, this trend is apparent. There is growing social concern about disability and appropriate compensation of the victims of accident, sickness and disease.

In his presentation, he went on to develop the case for universal accident compensation by examining a number of points:

- Disability resulting from product-related injury is a significant social problem.
- Nearly 75% of all accidental injuries are not work-related, however, it is in the non-work areas that disability income coverage is weakest.
- For most Canadians today, accident loss reparation consists of a complex number of plans ranging from no-fault compensation schemes, compulsory automobile insurance and a common law system based on tort. In Professor Belobaba's documented view, tort fails miserably both as a compensation and as a deterrence mechanism.
- Deterrence could be handled better under a comprehensive accident compensation plan through the use of penalty rating.

- Doubt was expressed that private insurance plans are capable of including non-workers and will probably always be incapable of guaranteeing inflation proof long-term periodic payments.
- The adoption of a universal accident compensation scheme even if the concepts of community responsibility are rejected would in the Professor's opinion be inevitable for reasons of institutional cost effectiveness alone.
- The establishment of a comprehensive accident compensation system would facilitate the logical and equally inevitable extension of this system to all disability, including sickness and disease.

Finally in his presentation, Professor Belobaba discussed a number of the problems that would be involved after acceptance of the concept of a universal accident compensation plan. He emphasized that it would be important to take the time to develop a well-conceived and properly designed plan to ensure as far as practicable that it would be complete, effective and efficient. In this regard, he suggested that it would be necessary to carry out additional research involving:

- A detailed understanding of existing first-party no-fault plans.
- A detailed understanding of tort related third-party liability insurance plans.
- Detailed understanding of current practices and problems of present public no-fault plans.
- The design of a proper system including the institutional, legislative, administrative and financial matters related to the entire scheme.
- Design appropriate federal and provincial safety regulations.
- Design public information and education programs.
- Expand the scheme to include all disability, including sickness and disease.

Canadian Union of Public Employees, Ontario Division (CUPE)

CUPE made two submissions to the Committee. The thrust of their presentations was that there should be a complete overhaul of the present system of accident and sickness insurance in Canada. The union's recommendations in this regard were summarized at the conclusion of its second presentation as follows:

- “1. The government of Ontario should immediately endorse the principle of a public universal sickness and accident insurance program covering all non-work and work related short and long term sickness and accidents, including partial, temporary and total permanent disabilities.
2. The government of Ontario should immediately establish a Royal

Commission to study the introduction of universal sickness and accident insurance.

3. The government of Ontario must be prepared to unilaterally introduce universal sickness and accident insurance, in the event that the federal government fails to do so, based on the criteria of:
 - (i) Social and community responsibility.
 - (ii) Comprehensive entitlement based on eliminating the differentiation between universal and employment related risks as a result of sickness and accident.
 - (iii) Complete rehabilitation.
 - (iv) Real compensation based on the income replacement approach using the criteria of maintaining a person's full net income.
 - (v) Administrative efficiency, including the co-ordination of sickness and accident insurance with Workmen's Compensation.
4. The public universal sickness and accident insurance program should incorporate the following features:
 - (i) A two week bridge period fully paid for by the employer during the waiting period prior to the commencement of U.I.C. sickness and disability benefits.
 - (ii) Integration and continuation of U.I.C. sickness and disability benefits for 15 weeks.
 - (iii) After 17 weeks the commencement of benefits under a compulsory public universal sickness and accident insurance program. The program shall include the following features:
 - Benefit Level: The benefit level should be 75 per cent of normal earnings up to the level of yearly maximum insured earnings (YMIE) of \$25,000 in 1978, and indexed to the average industrial wage, with a maximum benefit of \$18,750 per annum.
 - Contribution and funding shall be made on the following basis:
 - (a) Employee: A basic exemption on employee contributions of \$5,000 in 1978 and 20 per cent of the YMIE thereafter without any upper limit on maximum contributions.
 - (b) Employer: Contributions shall be paid on all salary and supplement income without any upper limit on maximum contributions.
 - (c) Funding: The program shall be financed as may be actuarially determined using the funded level premium method with a contingency reserve.

— Duplication of benefits and contributions such as the C/QPP disability pension shall be phased out after meeting their prior obligations.

5. Amendments to the pertinent legislation should be introduced so as to provide:

- (i) That part-time groups of employees and high risk categories must be allowed coverage under private sickness and accident insurance.
- (ii) That the standard definition of disability shall be of a five year “own” occupation definition of disability.
- (iii) That employers shall be responsible for maintaining employees on full salary during any waiting period prior to the commencement of public sickness and accident insurance benefits.
- (iv) Uniform minimum standards for rehabilitation programs under private sickness and accident insurance.
- (v) That any savings accruing to an employer from the termination of a sickness and accident insurance policy, as a result of the introduction of a public program, shall be shared with the employees concerned.
- (vi) That an independent adjudication procedure on benefit termination shall be established under the authority of the Ontario Insurance Commission and shall be applicable to all private sickness and accident insurance policies.
- (vii) Minimum standards for benefit indexation should be established.
- (viii) An employment guarantee to allow employees to return to their former or equivalent job after disability or rehabilitation.’’

In addition to these major recommendations concerning the revamping of the present system, CUPE noted, in reference to public programs, the need for integration and rationalization of—the definition of disability; eligibility for benefits; waiting period; duration of benefits; and level of benefits.

CHAPTER 18

Alternative Systems in Selected Countries Outside of Canada

A. INTRODUCTION

In recent years, a great many countries have expressed dissatisfaction with their system of accident and sickness financial protection for their citizens. Some countries have made drastic changes in their programs in the past decade. Others have carried out extensive studies of alternatives and are still debating the appropriate course of action. Still others have refined their systems gradually over the years. In the Committee's opinion, it is very useful to examine, if only briefly, practices in other countries of the world as it seeks to reach conclusions and develops recommendations appropriate to Ontario and Canada. As one witness appearing before the Committee noted—

“Historically social security developments in Canada have received their impetus from foreign examples. In the post-war period, for example, the 1945 federal social security proposals relied on Commonwealth and American experience. The government stated in its brief to the provinces at that time:

‘In developing its proposals with reference to old age pensions, the federal government has given careful attention to the experience of other countries (in particular the plans and proposals now in operation or under consideration in Great Britain, the United States, Australia and New Zealand)’ ”.

The Committee therefore has reviewed recent published information concerning practices in a number of countries. While the Committee does not suggest that its review has been extensive and designed to ensure that it appreciates fully the current status of the plans in force in each of the countries reviewed, it found the analyses most enlightening.

In the following sections of this Chapter, information is summarized concerning systems in a number of countries. More detailed comments are made regarding the systems and studies relevant to financial protection for accident and sickness in New Zealand, Australia and the United Kingdom. New Zealand is considered to have the most comprehensive universal system regarding income protection for those injured in accidents. Recent reports of commissions in Australia and the United Kingdom have gained the worldwide attention of those concerned with financial protection for accident and sickness. Brief comments follow concerning accident and sickness compensation in other countries—France; The Federal Republic of Germany; Sweden; The Netherlands; Switzerland; and the United States. The Chapter concludes with a few general comments regarding the schemes in other countries.

B. NEW ZEALAND

The New Zealand System of Compensation was introduced April 1, 1974 after more than ten years of consideration. Its origin was a paper prepared by a Committee on Absolute Liability set up in 1962 to examine and report on the desirability of introducing some form of 'absolute liability' for deaths and bodily injuries arising out of the use of motor vehicles. There was a general concern that all too often, disabled or incapacitated people received no financial compensation under the existing system. Further to the report of this Committee, which advocated a more realistic and generous system of compensation for injuries incurred through the use of motor vehicles and also for injuries for industrial accidents, a Royal Commission (the Woodhouse Commission) was established to inquire into aspects of compensation for personal injury from employment. Following the Royal Commission's report a white paper was presented and a Select Committee was then set up to report on the proposals of the Commission. The recommendations of the Select Committee were accepted by the government and a bill introduced in 1971, amended in 1973 and implemented as of April 1, 1974.

Compensation for Personal Injury Before Introduction of Plan

Generally speaking, the system of compensation before 1974 was through action for damages at common law.

In regards to work injuries, workers were provided compensation through the Workmen's Compensation Act. Benefits could stretch to a maximum period of six years and had a low upper limit based on earnings—the benefits were non-taxable.

Compulsory automobile liability insurance was enacted in 1962 to provide possible compensation to persons killed or injured by the negligence of the driver.

Other miscellaneous liabilities such as products liability and medical negligence also provided possible compensation through the law of tort.

New Zealand was the first country to introduce a criminal injuries compensation scheme which was administered by a crime compensation tribunal empowered to make an award whether the offender was convicted or not. This compensation took into account social security payments and workers' compensation benefits.

The Accident Compensation Act

(a) The underlying principles:

The following principles were established as the basis for an adequate disability compensation scheme:

i) Community responsibility:

As a matter of national interest and obligation, the community must protect all citizens from the burden of sudden individual losses when their ability to contribute to the general welfare by their work has been interrupted by physical incapacity.

ii) Comprehensive entitlement:

All injured persons are entitled to receive compensation based on a uniform method of assessment and regardless of the causes that gave rise to their injuries.

iii) Complete rehabilitation:

The scheme must be deliberately organized to promote prompt physical and vocational recovery of injured citizens while at the same time providing a real measure of fair compensation.

iv) Real Compensation:

Compensation demands for the provision of income related benefits for lost income and recognition that permanent bodily impairment is a loss in itself regardless of its effect on earning capacity.

v) Administrative Efficiency:

The purpose of the system will be eroded to the extent that its benefits are delayed, are inconsistently assessed or administered by methods that are economically wasteful.

(b) Objectives of the Accident Compensation Act:

Stated in general terms, the Accident Compensation Act has three broad objectives:

- i) to provide prompt, fair and reasonable compensation.
- ii) to promote prompt and effective rehabilitation,
- iii) to promote general safety with a view to preventing accidents and minimizing injuries.

The three objectives are considered equally important and form the bases through which a community problem is tackled by the community through its own community financed accident compensation system.

(c) Coverage under the Accident Compensation Act:

The Act comprises three different schemes as follows:

i) Earners scheme:

This scheme provides full time coverage against accidental personal injury to all employees and self-employed persons in New Zealand. This coverage can be extended to out of the country residents for up to a maximum of four years.

The scheme is financed by levies on employers with the rates determined by the industrial activity of the employer rather than the

occupation of the employee except for office workers and commercial travellers. The scheme operates within a wages ceiling.

The self-employed pay a flat-rate levy percent of business income with the same annual ceiling as wage earners.

There is also a provision which has not yet been implemented which provides for penalties or rebates for any employer or self-employed person whose accident record is significantly worse or better than the average.

‘Personal injury by accident’ as defined in the 1972 Act included incapacity resulting from an occupational disease with specified limitations. The definition, which is still not regarded as exclusive, was amplified by the 1974 Act to include:

- i. the physical and mental consequences of any injury or accident;
- ii. medical, surgical, dental, or first aid misadventure;
- iii. incapacity resulting from an occupational disease or from industrial deafness; and
- iv. actual bodily harm (including pregnancy and mental or nervous shock) arising from a criminal act.

Heart attacks and strokes were specifically excluded unless shown to be the consequences of an accident or to have been caused by abnormal, excessive or unusual effort, stress or strain in the course of employment. Also excluded, except as covered by i. or iv. above, was damage to the mind or body caused exclusively by disease, infection or the ageing process.

ii) Motor Vehicle Accident Scheme:

This scheme provides coverage for all people, earners and non-earners, who sustain personal injury through the use of a vehicle within New Zealand.

The scheme is financed by annual levies on motor vehicles and the Act also provides for annual levies on all holders of driving licences, the latter provision has not yet been implemented.

iii) Supplementary scheme:

The supplementary scheme covers anyone injured or killed by accident in New Zealand who is not covered by the two main schemes. Non-earners such as pensioners, homemakers and visitors to New Zealand are covered and can receive benefits other than earnings related benefits. Compensation for loss of potential earning capacity may be paid under the scheme.

(d) Compensation:

i) Loss of Earnings:

Earnings related compensation is payable to all earners, employees and self-employed persons, who suffer personal injury by accident

resulting in loss of earnings capacity whether total or partial. Nothing is payable for the first seven days when an accident occurs outside work or to a self-employed person. If the accident is work related, then the Act requires the employer to pay the insured person his or her full loss of earnings during the first week of the injury. Subsequently, the Accident Compensation Commission will pay weekly earnings-related compensation at the rate of 80%, in some cases up to 90%, of the amount of loss of earning capacity within a stated ceiling.

Employers may make voluntary compensation payments directly to employees in addition to the 80% rate generally paid by the Accident Compensation Commission but earnings-related payments may be reduced by the Commission so that no person receives more than 100% of his or her pre-accident earnings.

All earnings-related payments are taxable.

ii) Assessment of Earnings:

Although the Act has laid down guidelines for assessment purposes, particularly for the assessment of the earnings of the self-employed, it has also given the Accident Compensation Commission discretionary power to assess prospective earnings rather than adhere too rigidly to pre-accident earnings.

Earnings-related payments of compensation cease at the age of 65 but there is a special provision for injuries occurring to persons between the ages of 60 and 70.

The rate of compensation for permanent incapacity can be increased if earning capacity deteriorates, but the rate cannot be reduced if earning capacity improves.

iii) Provision for Low-Earners and Potential Earners:

Additional provisions for certain low income earners, namely, employees under age 21, apprentices and other trainees (on-the-job) provide for the relevant earnings of such persons to be increased from time to time to account for increases the employee would have received had he not been injured.

Compensation for potential earnings capacity is payable to young people under 16, and those who are studying or who have not commenced full time employment and who have suffered personal injury by accident. No earnings related compensation can be paid to persons under the age of 16 before the attainment of age 16.

Assessment of compensation in such cases is made as if the injured person was an earner and his or her relevant earnings at a flat rate per week established by the Regulations under the Act. This compensation may be increased where the injured person was studying or training for a career or profession.

iv) Compensation—Non-Pecuniary Loss:

Compensation for non-pecuniary losses is payable to non-earners as well as earners. A maximum lump-sum amount of \$7,000 (in 1979) is payable where the injury had resulted in the permanent loss or impairment of some bodily function or the loss of any part of the body.

An additional maximum lump-sum amount of \$10,000 (in 1979) is also payable for loss of amenities or capacity to enjoy life including disfigurements and for pain and suffering.

These lump-sum payments are non-taxable.

v) Compensation—Other Expenses:

In addition to all other compensation and rehabilitation assistance, the Commission may pay additional amounts as it determines for actual and reasonable expenses and proved losses necessarily and directly resulting from the injury or death.

Compensation may also be paid to any member of the injured or deceased person's household for any quantifiable loss of service proved to have been suffered. Such compensation would be payable for such period as the Commission thinks fit, not being longer than the period for which that member could reasonably have expected to receive the service.

The Commission is also required to pay for the reasonable cost of medical treatment and hospitalization to the extent that such costs are not met under the New Zealand Social Security system.

vi) Death Claims:

The commission is empowered to pay any reasonable funeral expenses of a person who dies as a result of accidental injury.

Earnings related compensation based on a percentage of the deceased's earnings at the date of his death is payable to dependent widows, widowers, children and other dependants. If a spouse was totally dependent on the deceased's earnings at the date of death, he or she is entitled to receive a defined percent of the earnings related to the compensation the deceased would have received had he or she lived but been totally, permanently incapacitated. Upon remarriage, dependent widows and widowers under age 63, receive a lump-sum payment equal to two years of the earnings related compensation applicable to them.

Dependent children are eligible for a smaller defined percentage of the earnings related compensation that would have been payable had the deceased not died but been totally, permanently disabled.

The total amount of earnings related compensation payable to dependants can never exceed the total amount of earnings related

compensation the deceased would have received had he or she not died, but been totally, permanently incapacitated.

Modest lump-sum payments are paid to totally dependent widows and widowers and each dependent child to a stipulated maximum for all the children of the deceased. Smaller sums are awarded for partial dependants.

vii) Self-Inflicted Injury:

No compensation is normally payable for any personal injury which a person wilfully inflicts on himself, or intentionally causes to be inflicted on himself or for death due to suicide unless suicidal death resulted from a state of mind that was the result of personal injury by accident. There is a statutory presumption, in the absence of proof to the contrary, that the death of any person was not due to suicide. Compensation may be paid on a discretionary basis to dependants of the injured or deceased who are in need of special assistance.

(e) Administration:

The Act is administered by the Accident Compensation Commission (ACC), consisting of three members one of whom must be a lawyer with seven years' experience in practice. The Commissioners are appointed for three years and are eligible for reappointment.

The Inland Revenue and Post Office are statutory agents for the collection of levies but the ACC may appoint private insurance companies and other bodies to be its agents as well.

The ACC is required annually to review levy rates, relevant earnings limits and, levels of lump-sum payments, to make actuarial reports and to make recommendations to the Minister of Labour on any necessary adjustments to the scheme.

(f) Appeals:

There is a system of appeals available to claimants.

Existing Systems to be Replaced

The implementation of the new scheme resulted in the supplanting of the existing Workmen's Compensation system, third-party motor vehicle insurance and the common law of negligence or tort.

It was a recognized fact that the Workmen's Compensation system did not promote the rehabilitation of the injured worker, offered only limited protection and was costly to administer.

As far as the common law is concerned, it is inherent in the new legislation first, that neither the issue of entitlement, nor the attribution of responsibility can be justified by implications of personal fault that are tested

quite impersonally. Secondly, the fault philosophy does not have any rational bearing upon the distribution of compensation that is really a charge upon the community. Third, the negligence concept is not used to assist the injured but to avoid payments to a large number of them on the grounds of economy. Fourth, the common law process tends to result not in the fairest solution, but in the best possible bargain. Fifth, it awards once-and-for-all lump-sum payments because future payments cannot be controlled conveniently by the courts. Sixth, lump-sum awards tend to result in the extremes of over or under compensation. Seventh, the common law system is unable to make provisions for the erosion of capital by inflation. Eighth, the system keeps a good many claimants with permanent disabilities waiting an unreasonable length of time for their damage compensation. Ninth, the common law hinders the rehabilitation of injured persons and finally, it plays no effective role in the prevention of accidents.

Other Social Benefits in New Zealand

(a) Health and Medical Services

The central government provides the encouragement, the financial assistance, the incentives and assumes final responsibility in the health and medical services field. Most benefits such as—medical, pharmaceuticals, hospital, psychiatric, maternity, X-Ray, laboratory, physiotherapy, domestic assistance, are free under the national health scheme with some limitations. For some services, medical practitioners may bill in excess of the government's share of the cost.

There is also a companion private sector health insurance plan for those wishing to undergo private treatment. Both the national and private plans are similar to the ones in operation in the United Kingdom discussed in some detail later in this chapter.

There exists a good mixture of both public and private hospitals. Private hospitals may invoice over and above the government's established share of costs.

The provisions of the Social Security Act that relate to medical care apply to cases of injury as well as disease. The general principle is that in the case of the accident compensation system, the ACC pays the medical costs over and above those assumed by the medical care plan, i.e. those costs that would be the responsibility of the patient. Care and treatment in a public hospital is generally covered by the Social Security Act. Therefore the ACC pays only for any supplemental services not covered by the Social Security System when an accident victim is in a public hospital. The ACC does not operate medical facilities either for acute care or for clinical rehabilitation.

Since treatment in private hospitals is not covered under the Social Security Act and is generally viewed as unnecessary by the ACC as treatment

in public hospitals is available, the ACC does not generally pay the cost of private hospital care. It may however, in some instances, usually involving elective surgery, agree to the treatment being provided in private hospital and will pay the whole cost; in some cases a compromise with the ACC is reached to pay part of the cost.

Regardless of whether a private or a public hospital is used the ACC pays the whole cost of ambulance service.

Dental costs differ from medical costs. There is no general dental insurance plan in New Zealand and in the case of dental damage in accidents, the ACC usually pays the whole cost.

(b) Social Welfare

Social welfare is financed through general taxation. The main features of the program are:

- Eligibility is based on residence for varying qualifying periods and is not based on tax paid.
- Benefits are subject to an income test.
- No tests are required for national superannuation and family benefits.
- Contributions are under a graduated income tax system and payment of benefits is made at a flat rate.

Central government assistance is offered to religious, voluntary and local authorities. In the case of caring for the aged, it becomes a hospital board's responsibility if the required services are not met by any of the other agencies.

(c) Unemployment Benefits

Benefits are related to earnings and the eligibility test is similar to the Canadian program.

(d) Superannuation and Provident Funds

In addition to the benefits provided under the national schemes, the government, local authorities and an increasing number of private employers operate superannuation schemes to enable employees to make provision for their retirement.

The Government Superannuation Fund, established in 1948, is funded by members' contributions, subsidies from the Consolidated Revenue Account, trading departments and other bodies, and interest earned on investments. This scheme is compulsory for all government employees and contributions come from deductions out of basic salary and works on a sliding scale to age. Contributions range from 6% to 11%. The principal objective of the fund is the payment of an allowance on retirement, which is usually between ages 60 and 65 years. Overall, the fund provides flexibility for earlier retirement, lump-sum payments and varying rates of allowance payments. A cost-of-living adjustment feature has been in effect since 1969.

The National Provident Fund, established in 1911, provides a superannuation scheme for the general public, local authorities and other bodies. The fund provides services in the following areas:

- Public Fund—The oldest scheme catering to the general public on an individual basis or as members of a group. Membership is not closed but was open to any resident of New Zealand over the age of 15 years. A state subsidy of 25% is built into the contribution rates for the first \$20-per week contributions and after 5 year membership, contributors qualify for incapacity, widow's and dependent children's allowances. This fund also provides a scheme on a "when and whatever amount contribution" basis.
- Local Authorities Superannuation—There exist three schemes which cover employees of all local bodies, quasi-government and other approved organizations, i.e. firemen and nurses.
- National Superannuation Schemes—Two employer-subsidized schemes are available, one for farm employees and the other for any employee or companies, firms, Government departments, or local authorities willing to become contributing employers. Another scheme is available for the self-employed.

In 1977, a scheme was introduced under the National Superannuation Fund to provide superannuation to all New Zealanders over 60 years of age who meet a 10-year resident qualification test.

Contributions to the National Superannuation Fund form part of the graduated income tax system and payment of benefits are at a flat rate irrespective of contributions—i.e. taxes paid. In the community interest there exists no right to "contract out" on the grounds that the individual may not need, or qualify for public aid.

All superannuation benefits are taxable.

(e) War and Rehabilitation Pensions

Created to provide basic pensions to compensate for disablements or deaths that are war related. These pensions are compensatory in character and provide for supplementary pensions to meet loss of income if applicable.

Some Observations on the New Zealand System of Accident Compensation

The present system of accident compensation in New Zealand has been in operation for more than six years and it is possible now to make some general observations concerning it against the background of its experience.

In general, the consensus seems to be that the scheme is successful probably because the range of claims as they relate to accidents closely parallels what might be granted by the courts under the traditional negligence

system—pecuniary and non-pecuniary losses are covered, expenses, including those of people helping victims to recover after the accident are included and all of this is done without having to resort to the erratic and difficult procedure of the rules of common law. Further, the amounts which may be granted under the plan are in general quite substantial. There is little or no evidence of any criticism in New Zealand of the amount of compensation offered. The New Zealand scheme and its basic strategy has unified the approach to all kinds of accidental injury. The basic tenet is that similar injuries merit the same amount of compensation whether the injury is incurred through a work accident, an automobile accident, an accident in the home or an accident during recreation. While it remains that an earner will obtain more compensation after an accident than would a non-earner, this results from the fact that he has more to lose not because his claim is being dealt with on a different conceptual basis.

By way of general commentary, while there have been some suggestions that the system is too complex and is inefficient, two recent reviews by non-residents of New Zealand indicate that the methods of administration are straightforward and appear to be efficient when such criteria as the number of people employed by the Commission to handle claims, and the speed with which claims are processed, are applied.

However, there are problems with the scheme, in particular:

(a) Deciding Whether Claimants are
Entitled to Compensation

The system generally covers all cases of “personal injury by accident” without reference to fault and without inquiry as to the cause and generally without any qualifying requirements. This universality of coverage helps to avoid concern on the part of claimants and facilitates the administration of the system. However, the principle of universal coverage while it has been applied to injuries does not cover all disabilities. The key in deciding whether an applicant is entitled to compensation lies in the phrase “personal injury by accident”. As Terence G. Ison indicated in his recent book “Accident Compensation—A Commentary on the New Zealand Scheme”—“There is no comprehensive definition of that phrase”. Reading Section 2 and 105B of the Act together, however, they provide that:

“ ‘Personal injury by accident’—

(a) Includes—

- (i) The physical and mental consequences of any such injury or of the accident:
- (ii) Medical, surgical, dental, or first aid misadventure:
- (iii) Incapacity resulting from an occupational disease or industrial deafness to the extent that cover extends in respect of the disease or industrial deafness under section 65 to 68 of this Act:

- (iv) Actual bodily harm (including pregnancy and mental or nervous shock, suffered by any person) by any act or omission of any other person (being an act or omission that occurs in New Zealand after the commencement of this section), and it is proved to the satisfaction of the Commission that the act or omission is within the description of any of the offences specified in sections 128, 132, and 201 of the Crimes Act 1961 . . . irrespective of whether any person is charged with the offence:
- (b) Except as provided in the last preceding paragraph, does not include—
 - (i) Damage to the body or mind caused by a cardio-vascular or cerebro-vascular episode unless the episode is the result of effort, strain, or stress that is abnormal, excessive, or unusual for the person suffering it, and the effort, strain, or stress arises out of and in the course of the employment of that person as an employee:
 - (ii) Damages to the body or mind caused exclusively by disease, infection, or the ageing process:”

Thus, Mr. Ison went on to explain, the following categories of disease are covered:

- “(a) Any disease that is a consequence of a compensable injury or a consequence of the accident. For example, where a wound is compensable, a disease resulting from the infection of the wound would be compensable.
- (b) Occupational diseases.
- (c) A disease resulting from ‘medical misadventure’
- (d) Any disease wilfully inflicted by one person upon another in violation of section 201 of the Crimes Act, 1961.

Subject to those exceptions, the general rule is that disabilities and deaths resulting from disease are not covered.

Exactly what proportion of newly disabled people are covered by the Act is unknown. But it is clear that only a minority of disabilities and deaths result from injury by accident. For example, of the deaths occurring in New Zealand in 1975 among people aged 20-59 years, only about 17 per cent were classified as resulting from accidents, poisonings or violence. Of all patients aged 20-59 years who were discharged from or died in hospitals in New Zealand in 1974, only about 12.5 per cent were classified as cases of accident, poisoning or violence.”

It is therefore essential that the ACC simplify and decide efficiently what is and what is not a “personal injury by accident” over time. This appears to

be done by the ACC as they refine the definition of "accident" to cover only unusual events, excluding injuries which occur during the ordinary course of events. Coupled with this is the idea that "accidents" connotes some sudden injury, rather than an injury that occurred gradually or over a period of time. The definition of "personal injury by accident" is being developed and refined by precedents by the ACC.

(b) Sickness

For disabilities not covered by accident compensation the earnings of workers are frequently maintained by sick pay for the first short period of time. Many employers have a formal sick pay plan. The most universal provision for disabled persons other than by accident is the sickness benefit payable under the Social Security Act. However, in the design of sickness benefit, the objective of floor level income support features much more prominently than any objective of income insurance.

It is of particular interest that the Woodhouse Commission in its report could find no logical reason for excluding disease from the new compensation system. It eventually agreed to defer the inclusion of disease coverage but concluded in its report that "the proposals now put forward for injury leave the way entirely open for sickness to follow whenever the relevant decision is taken." This continues to be one obvious potential problem of the relatively comprehensive compensation scheme in New Zealand in that it is confined to accidents alone. There is potential for difficulties in administering the present scheme in differentiating and rationalizing the payment of compensation for accidents as opposed to sickness. The chairman of the Accident Compensation Commission, Mr. K. L. Sandford in an annual report noted that the scheme may well be extended in due time and ultimately "the memory of the common law system may become sufficiently overgrown and remote that the victims of accident will no longer be regarded as deserving of special attention . . . it is possible that the generous benefits of accident compensation would have to be reshaped, very likely reduced, to conform with an equal and more economically practicable provision for the victims of all such disabilities."

(c) Administration of the Scheme

The system has been accused of being unduly complex and administratively cumbersome. Probably the most difficult of the problems relating to the scheme arise from the question of whether common law precedents and principles have any role to play in the new arrangements; and secondly, whether the ACC's own decisions form precedents. The Commission has made it clear that the common law precedents have no place in the scheme and hence are not to be relied upon by claimants. Regarding the matter of the ACC establishing its own precedents, the Commission thus far has indicated that it does not bind itself by its decisions and that its decisions made at any time are meant to be expressions of its policy at that time. However, in the interests of consistency the Commission expects to follow the same general lines of reasoning in its decision unless new policy considerations arise.

(d) Abuse of the System

As with most systems of injury compensation there have been allegations of abuse. In particular, there have been suggestions that disabilities from natural causes or non-work accidents are being attributed to work accidents. There have been some allegations of unnecessary absences from work for minor injuries, or absences for longer periods than necessary.

(e) Financing the Plan

The most important problem which has arisen concerns financing the plan. As has been indicated the New Zealand scheme consists of three separate funds. First, there is the earners scheme which covers all injuries suffered by the employed or self-employed; this scheme is financed by a levy on employers and the self-employed. Secondly, there is the plan for compensation of persons injured in road accidents. This is financed by a levy on vehicles depending upon class. Third, there is a separate fund financed from national revenue for anyone else injured or killed by an accident in New Zealand. Each of these schemes is administered independently although overall coverage is comprehensive.

The alternative ways of funding any such scheme might be classified as:

- current cost funding, whereby the costs payable in each year in respect of current claims and all past claims would be payable out of revenues accruing in that year i.e. a pay as you go system.
- full funding, whereby revenues would be raised in each year to meet the current and future cost of accidents occurring in that year.
- a compromise between or variation of the above.

Concerns have arisen and were expressed in the ACC's 1978 annual report as to whether the balance in the earners' fund is adequate on a full funding basis. The problems of inflation during the years of operation of the scheme have compounded the financing problems of each of the funds but the earners' funds in particular. In 1979, the now Sir Owen Woodhouse expressed the view that he was emphatically in favour of current cost financing of each of the funds.

(f) Political Considerations

The New Zealand system of accident compensation was conceived in an atmosphere of relative insulation from political pressure. However, now that the funds are in operation with the vast amount of money involved some argue that the Commission ought to be under greater government control. This is viewed by others as a regressive step particularly in the concept of the establishing of appropriate levy rates and the methods of financing the funds. An example is used in connection with the review of the motor vehicle accident scheme in 1977 and 1978 when the ACC discovered that motorcycle accidents were costing them "a small fortune". The Commission, therefore, proposed to increase the levy on motorcycles substantially. However, the

government refused to sanction this proposal and only a relatively modest increase was allowed. This raised concern that if significant increases were required from employers similar government interference might be anticipated.

(g) The Level of Levies

The actual levies themselves are a cause of some complaint. While the Commission has the power to vary levies on employers and drivers with exceptionally poor records, it has chosen not to do so. There are arguments pro and con with which the Commission is concerned. It is also considering the possibility of a flat rate, rather than a variable system of levies on employers but views this as a political rather than a “funding” decision.

The ACC has always acknowledged that the levying and compensation for self-employed is fraught with exceptional difficulties. The problem of the exact earnings of the self-employed makes it difficult to collect the correct levies and subsequently to assess a loss of earnings of an injured self-employed person. Additional complications arise with those starting new businesses; farmers and others employing replacement help.

(h) Deciding the Degree of Impairment

A problem that has always confronted the Commission has been the final assessment of the degree of impairment of permanently injured victims of accident when his or her condition has stabilized. Even after six years of operation the ACC has really only begun to wrestle with the problem of these assessments and the difficulties that they involve. The Act itself creates a problem for the Commission in that the earnings related compensation which is paid to injured persons can be increased if the claimant’s condition worsens but cannot by law be decreased if his or her condition improves. This feature of the plan has been criticized as over-generous.

(i) Lump-Sum Payments

The New Zealand scheme allows for the payment of lump-sum payments for the loss or impairment of any bodily function and also for the loss of amenities, pain or nervous shock. Rulings of the ACC have been appealed most often in regard to lump-sum payments and it is in this area that the Commission is seeking to rely on the establishment of precedents.

(j) First Week’s Lost Wages

When an earner is injured at work, his employer pays the first week’s lost wages. One of the justifications for this provision relates to its deterrence and accident prevention aspects in so far as it brings directly to the attention of the employer the fact that accidents are occurring. The more accidents which do occur then the more obvious this should be to management in the number of claims and the amount of wages paid to employees in this regard. On the other hand, some feel that when accidents do occur, the injured employee

may be exaggerating his suffering and he has no incentive to resume work after a slight injury since he will suffer no financial loss for one week.

C. AUSTRALIA

Following their visit to Australia, the Royal Commission on Civil Liberty and Compensation for Personal Injury under the Chairmanship of Lord Pearson noted in their report:

“Provision in Australia for compensation in respect of personal injury is based primarily on the common law of each state. General social security provision by way of cash benefits is usually subject to tests of income and residence; hospital and general medical care is provided through a federal scheme and by private arrangements with varying charges on the patients. Special legislation covers all employees on a no-fault basis against injury at work. Compensation for injury sustained in road accidents is normally subject to the common law, but in two states limited no-fault schemes operate. Proposals for a federal no-fault system of compensation for personal injury were incorporated in draft legislation, but with a change of Government towards the end of 1975 the subject was referred for a complete re-examination.”

It is the Committee's understanding that this legislation is still in abeyance.

Medical Care

The Pearson Commission in referring to medical care in Australia explained that under the provisions of the Health Insurance Act 1973, effective July 1, 1975 the provision of benefits for medical care was changed by the introduction of a health insurance scheme known as Medibank. This scheme, administered by a central Health Insurance Commission, was originally financed directly from general revenue and covered everyone in Australia. However from October 1, 1976, Australians became entitled to choose whether to remain in Medibank or to transfer to a private health fund. The method of financing health insurance was also changed. Medibank Health Insurance is now financed from federal revenue and from a levy on taxable income. While most pensioners and others on low income continue to pay nothing for Medibank Health Insurance, earners pay a percent based on taxable incomes up to a maximum dollar amount each year to cover medical and hospital, standard ward treatment.

Private health insurance is obtained through contributions to private health funds.

A doctor may either charge a Medibank member directly for services rendered or claim a pre-established percent of a schedule of rates by settling with the Health Insurance Commission. In this event the doctor may charge

the patient nothing or the additional percent up to the maximum of a specified dollar amount per service. Patients who are charged directly and privately insured patients pay the doctor and are refunded the same percentage of the schedule rates from Medibank or the private health fund to which they belong.

The federal government pays $\frac{1}{2}$ of the agreed operating costs of the state public hospitals. The state governments undertake to provide standard ward accommodation and treatment in public hospitals without charge to Australian residents who are not privately insured. Those who are privately insured, or those who opt for private treatment, are entitled to choose their own doctor in hospital and are charged established dollar fees per day by the hospital depending on the standard of accommodation. Payment to the doctor for treatment is on a fee for service basis. The federal government pays a portion of the bed-day cost of patients accommodated in private hospitals.

Committee of Inquiry

In 1973, the then Labour Government decided in principle to establish a national compensation and rehabilitation scheme. A Committee of Inquiry was appointed with the following terms of reference.

“To inquire into and report on the scope and form of, and the manner of instituting and administering, a National Rehabilitation and Compensation Scheme appropriate to Australia, and which in principle the Australian Government has decided to establish, for the purpose of rehabilitating and compensating every person who at any time or in any place suffers a personal injury (including pre-natal injury) and whether the injury be sustained on the road, at work, in the home, in the school or elsewhere or is an individual disease with particular reference to:—

- (a) The circumstances in which an injury should be covered;
- (b) The application of the scheme where death results from the injury;
- (c) The nature and extent of the benefit that should be provided;
- (d) How the scheme should be financed;
- (e) The relationship between benefits under the scheme and other social service benefits;
- ((f) Whether rights under the scheme should be in substitution for all or any rights now existing;
- (g) The encouragement of precaution against accident;
- (h) The provision of rehabilitation facilities; and
- (i) The manner of administering the scheme.”

In February 1974, the Committee's terms of reference were extended to include sickness as follows:

“And further to inquire into and report on any extension of the scheme for the purpose of rehabilitating and compensating every person who suffers a physical or mental incapacity or deformity by reason of sickness or congenital defect, together with the application of the scheme where death results from such sickness or defect”.

The Committee of Inquiry consisted of the Honourable Mr. Justice A. O. Woodhouse DSC, a Judge of the Court of Appeal of New Zealand, Chairman, and the Honourable Mr. Justice C. L. D. Meares, a Judge of the Supreme Court of New South Wales. The Committee is often referred to as the Woodhouse Committee. The Committee reported to the parliament of the Commonwealth of Australia on July 10, 1974 with a report consisting of three volumes—Volume I—The Main Report; Volume II—Rehabilitation and Safety; and Volume III—The Compendium.

It is generally acknowledged that the Woodhouse Committee conducted the most thorough review of a comprehensive national sickness and accident scheme yet undertaken.

Summary of the Woodhouse Report

A recapitulation of the conclusions and recommendations of the Committee follows:

(a) Purpose of Report

The report is concerned with the responsibility of society for the injured and the sick. Its theme is their need for automatic rehabilitation and compensation—without tags and without discrimination. The recommendation is for generous earnings-related compensation at every level of income up to \$A 26,000 per annum (Note). In consequence, the present social security system of pensions that aims merely at an income for subsistence would need to be replaced. At the same time the new scheme would supplant the action at law based upon fault. And the general scheme of workers' compensation would disappear. In their absence, risks relating to those remedies there would of course, no longer be a basis for any form of compulsory insurance.

Social problems in the past have been handled in a piece-meal fashion.

(b) The Problem of Injury

The magnitude of the personal injury problem has made it a 20th-century affliction. Earlier generations faced nothing like it. Today, the casualties are unending. Every year 3,600 Australians

Note: The 1974 \$A was equal to Can \$1.40, therefore the \$A26,000 amount would be equal to Can \$36,400. The average industrial wage in Australia in 1974 was Can \$7,685 and that in Ontario was Can \$9,435.

are killed on the roads alone. More than 90,000 are injured; five times as many as are the victims of work accidents. Even larger numbers are casualties elsewhere.

Yet, there are still those who point to the fault of individuals as the basic cause of accidents. Arguments are still advanced that it is right for innocent victims to be left to fend for themselves if they cannot find somebody to blame for their plight.

In the name of social progress, all of us pursue activities that exact an inevitable cost in life and limb: and we continue to tolerate that cost, grim as it is, simply because the balance of convenience and utility seem to be worth it. In terms of social conscience, it is remarkable that the community has not insisted long ago that at the very least losses of the injured should be borne by the community as a whole.

To the extent that the conscience of the community is at work, it is content to operate through three entirely different remedies that provide or withhold assistance with almost capricious detachment. The negligence action is marked by years of delay, by uncertainty, by avoidable expense and by much disappointment. The workers' compensation legislation turns a blind eye to the risks faced by every workman during the greater part of the day; it does nothing whatever for the housewife. The social security system will assist with the pressing needs of others, provided they can meet the means test—but it does so by providing equal flat-rate benefits for losses that vary from case to case.

(c) *Sickness*

The needs of the sick are even more neglected. In terms of equity, therefore, and as a matter of logic, there should be equal treatment for equal losses. There is an obvious need for the compensation scheme to include all persons who are physically incapacitated.

(d) *The Philosophy*

If there is to be a co-ordinated response to the many levels of the problem of physical and mental incapacity, there must be a basic framework of coherent and interlocking principles. There must be responsibility universally accepted and shared in return for rights comprehensively available and enjoyed. There must be effective rehabilitation and compensation offered to all. And the assessment and distribution of benefits must be achieved on a basis that is efficient, consistent and just. These are the general principles that should govern a modern universal system of compensation for sickness and injury—community responsibility; comprehensive entitlement; complete rehabilitation; real compensation; and administrative efficiency.

(e) Community Responsibility

For three main reasons the community must accept the obligations that are clearly owed to every person who has been struck down by sickness or by injury. First there are the civilized reasons of humanity. Next, there are the economic reasons of self-interest. If the well-being of the work force is neglected the economy soon will suffer injury and society itself thus has much to lose. Finally, there is the plain fact that rights universally enjoyed must be accompanied by obligations universally accepted. Moreover for these three principal reasons, the scheme must be accepted as an aspect of social welfare; and it must be organized as a responsibility and function of the state.

(f) Rights Universally Enjoyed

The second principle is the concept of comprehensive entitlement. It requires that all should be eligible to share in a scheme supported by funds to which all have contributed. It rightly calls for equal treatment for equal claims. It would be wrong to exclude from such a scheme victims of criminal injury, or members of the armed forces, or those temporarily overseas or homemakers. It would be equally wrong to include those in employment and exclude others who are self-employed. Nor would it be right to limit benefits within some cautiously contrived ceiling of earnings. In times of adversity, those who have contributed according to their means should be assisted according to their sudden needs. The aim must be an integrated solution for every man and woman and protection throughout the 24 hours of every day. The primary purpose of the scheme is to provide cover in respect of personal capacity for everybody.

(g) Incentive

The primary objective of the scheme must be to encourage every incapacitated person to recover the maximum degree of bodily health and vocational utility and social well-being at the earliest possible time. That objective must never be impeded. On the contrary, every incentive must be built into the system for the promotion of personal effort, individual reliance and final self-respect. Through rehabilitation, the scheme will provide the incentive to get well. It will offer the real incentive that is given to people who know their entitlement to assistance will be thoroughly measured against this real need. By offering compensation at 85% of past earnings, it will replace almost the whole of a person's losses without the over compensation that would arise if earnings were replaced in full and without some appropriate deduction for the traveling and other expenses of the working week that had been saved. At the same time if the scheme is to receive the public support

it requires and deserves, it must not be involved in misplaced gestures of easy and unneeded help for every minor ache and pain.

(h) Prevention and Rehabilitation

The problem of incapacity, whether arising from injury or from sickness, demands an attack on three fronts. The most important is prevention. Next in importance is the obligation to rehabilitate the injured and the sick. Finally, there is the need to provide economic assistance in the form of compensation for their losses.

For the promotion of safety in the injury field, it is proposed to establish a National Safety Office. It will have as its primary responsibility the co-ordination of policy, planning and efforts throughout the country; and the assembly and integration of statistics which, for the first time, will become available through the compensation scheme in respect of every accident of every type occurring anywhere in the country.

To promote rehabilitation, organization and administrative responsibility will be concentrated as a single division of a social welfare policy and planning department; with rehabilitation in all its aspects—medical, vocational, educational and social—encouraged as a total concept.

(i) Level of Benefits

To meet real losses, compensation is to be provided at levels that are geared to individuals' social and economic needs. The primary objective is the maintenance of living standards by the maintenance of earnings wherever they are interrupted by misfortune. The levels of compensation must be realistic for all. Philosophies which were content to provide meagre benefits related merely to need must be set aside. Real compensation demands the provision of income-related benefits for lost income throughout the whole period of incapacity and the opportunity for every incapacitated person to maintain the living standards he or she had earlier achieved by energy and hard work.

Accordingly, it is proposed that employees and the self-employed should receive taxable compensation at the rate of 85% of previous taxable earnings up to a maximum weekly earning of \$500. At the other end of the scale, there will be a minimum weekly figure of earnings of \$50 against which benefits will be assessed; and the same figure will apply on a notional basis to housewives and others who are not in receipt of earnings. Special provisions which enable the potential earning capacity of younger people to be taken into account and provisions that should enable an appropriate figure of earnings to be calculated in the case of persons with seasonal work are a part of this scheme.

To encourage the offer and acceptance of suitable work in the case of convalescent employees able to do only light work there will be a convalescent allowance designed to subsidize or make up wages to normal weekly earnings and payable at a rate not exceeding 50% of the average relative earnings of the employee.

Members of the work force will be subject to a waiting period of seven days on the principle that there are widespread sick leave entitlements in the case of employees, and employers are usually able to make suitable arrangements for themselves during that short period. For administrative reasons primarily, those who are non-earners will be subject to a waiting period of 21 days. In all cases, payment of benefits will continue until age 65, when it is expected the National Superannuation Scheme will take effect.

There are appropriate provisions for surviving dependants, together with an immediate and additional lump sum payment of \$1,000 for all widows. Reasonable funeral expenses would be paid.

(j) Permanent Partial Disabilities

A permanent partial loss of normal physical or mental faculty can have effects that vary from case to case; and the assessment of the effect can be undertaken either by an individual evaluation, or by the application of a general formula that will produce broad and acceptable justice. To avoid delay and the adverse effects upon rehabilitation, it is proposed that in the case of permanent partial disabilities the assessment will be made against the published index of average weekly earnings except in those cases where such an approach would produce an unfair result for the individual concerned. Some disabilities can have hard effects upon the earning capacity of particular individuals. For that reason there must be a benevolent exercise of discretion to depart from the base of average earnings in the case of any partially incapacitated person able to show that the use of average earnings would result in under-compensation. In such a case actual earnings would be the base.

There is a need to provide for cosmetic impairments of real significance. They should be compensated by a lump-sum payment ranging up to a maximum of \$10,000.

(k) Periodic Benefits

The basis of this scheme is periodic payments of compensation as a far superior method of payment to any lump-sum settlements. It avoids speculation about the future and the adequacy of any lump-sum payments. The payments are available to meet losses as they arise. They can be assessed and paid without delay. They have the great advantage in that they can be adjusted to meet the adverse effects of inflation following upon the initial assessment. Moreover,

they can be varied upwards to meet any adverse change in individual circumstances, although to avoid any chance of discouraging commendable efforts to self-help, a benefit once given should not later be reduced.

(l) Automatic Adjustments for Inflation

It would be wrong to permit periodic benefits to fall with the falling purchasing power of money. There is a need for long-term beneficiaries to be left with the feeling that society will permit them to share to some degree in the increasing prosperity of the country as productivity in real terms continues to increase. Accordingly, it is proposed that automatic adjustments of all benefits take place at quarterly intervals in accord with changes in the consumer price index.

(m) Retrospective Incapacities

The scheme should look back to include past injuries and sicknesses that have gone unassisted by common law damages or workers' compensation for those who have been left with continuing effects. As a matter of equity, there can be no doubt that the citizens still burdened by some earlier affliction have every right to be considered as eligible beneficiaries of a new and broadly-based social system. There can be no valid reason for excluding this important and deserving section of handicapped people. It is proposed that all should receive appropriate benefits provided they have exhausted their rights under the existing schemes of the common law and workers' compensation.

(n) The Insurer

There are four principal reasons why the new scheme cannot be administered within the general framework of insurance. First, the proposals amount to a wide-scale reform of the whole structure of the social welfare system. They will require the collection and distribution of public funds. None of the issues raised are of a commercial nature. Nor are they legal issues. They are social issues. Thus the whole project is an inevitable and natural function of government. The second reason is that contention and dispute must not be allowed to interfere with the evaluation and assessment of applications. Thirdly, it would be an unacceptable extravagance to increase the costs of administration from the amount needed by a government department to those required for administration by the insurance industry. Fourthly, the Commission believes that the industry has been disengaging from the general area of social insurance, owing to the intractable problem of inflation and the extreme difficulty of assessing on any sound and commercial basis the level of premium intake required from year to year.

(o) Administrative Efficiency

A basic principle of the scheme is administrative efficiency. To the extent that rehabilitation or compensation is delayed, or benefits are inconsistently assessed, or the system is administered by methods that are economically wasteful, so will the achievement of any welfare system be eroded. There is a clear need for the new process to be handled on a co-ordinated basis and for the collection of funds and the distribution of benefits to be organized promptly, consistently, economically and without contention.

Throughout its report, the Commission indicated the following conclusions among others.

Regarding the Value of the Negligence Action

“Our conclusions concerning the common law in the context of claims for personal injury are summarised in the following sub-paragraphs:

- (1) Neither the issue of entitlement nor the attribution of responsibility can be justified by implications of personal fault that are tested quite impersonally.
- (2) Nor does the fault philosophy have any rational bearing upon the distribution of awards that are really a charge upon the community.
- (3) The negligence concept is used not to assist the injured but to avoid payments to large numbers of them on grounds of economy.
- (4) The ostensible purpose of the system is to measure real losses in order to provide equal damages in return: but by permitting the fiction to survive that the trial is a contest between individuals the process becomes an attempt to achieve not the fairest solution but the best possible bargain.
- (5) Lump-sum awards are required not because future losses ought to be paid for at once but because future payments cannot be controlled conveniently by the courts.
- (6) The disembodied attempts needed to prophesy the future in terms of a once and for all payment now, can only fortuitously avoid over-compensation on the one hand or under-compensation on the other.
- (7) The attraction of capital in hand is illusory: and if the fund should be exhausted too readily, there could be calls upon the social security system for relief and a consequential second payment for the one injury.
- (8) The system is quite unable to make provision for the erosion of capital by inflation: indeed, there is a downright injunction that the factor of inflation must be totally excluded from the assessment of damages.

- (9) In the more serious cases, at least one-fifth of successful plaintiffs have their assessed losses reduced by average amounts that range from no less than 30% in Queensland up to a figure of 49% in New South Wales.
- (10) The system leaves at least half of all the claimants with permanent disabilities waiting for their damages for more than two years; significant numbers are still unpaid after four years; and in some instances the cases have not been finalised after five.
- (11) The adversary system hinders the rehabilitation of injured persons after accidents and can play no effective part beforehand in preventing them.
- (12) The Courts are left in 1974 still grappling with litigation based on issues that today give rise not to legal problem but to a social problem of great magnitude. The time has arrived for their release.’’

The Social Welfare Objective

- “(1) A compulsory and universal system of compensation for incapacity, supported by public funds, must be regarded as a function of government.
- (2) Emotive talk that the administration of such a fund involves an element of socialisation of business is a palpable misuse of language.
- (3) The maintenance of living standards clearly demands the support of lost earnings with earnings-related compensation. And the earnings losses should be supported at every normal level of income.
- (4) The objective of income maintenance cannot be achieved by the provision of flat rate benefits; while the means test concept is completely antipathetic to the whole concept of earnings-related compensation.
- (5) There is no evidence that the problem of malingering is of more than minimal proportions. In any event, by the application of firm medical administration, few real malingerers are likely to go undetected.
- (6) Every support must be offered to personal initiatives to get well and resume work. The compensation scheme has been designed to provide incentives for individual effort and to avoid impediments to rehabilitation.
- (7) There is a need for co-ordination and planning over the whole field of social welfare and health and this could best be achieved by a social welfare policy and planning department.

- (8) The rehabilitation objective can best be realized by the establishment of a special division within the policy and planning department charged with the responsibility of promoting medical, vocational, social and educational rehabilitation as a total concept.
- (9) The National Safety Office recommended in Part 7 of the Report should be associated with the policy and planning department as an 'outrider' organisation.
- (10) The scope and breadth of the compensation scheme logically requires that it should become the responsibility of the present Department of Social Security; but it may be thought worthwhile changing the name of that Department in order to describe its future function and purpose."

Sources of Funds To Finance The Scheme

Part IX of Volume 1 of the Committee's report dealt with a number of financial and statistical aspects of its review and in particular the sources of funds to finance the scheme. The Committee's conclusions may be summarized briefly as follows:

- (a) A comprehensive system of social insurance involving community responsibilities should be supported by community contributions. It could therefore be argued that the state should finance the proposed scheme without demand upon special groups. However, there are two reasons why that principle should be modified. First, the proposed scheme will remove the risks at present covered by two compulsory insurance schemes and thus remove the need for insurance and the consequential need for premiums. In effect, the cost of premiums has long since been built into the costs of industry or transport and so passed on to the public at large as a sort of disguised sales tax. If industry in general were to be entirely relieved of the payments as the result of a decision to meet the cost of the new scheme out of general taxation, the effect would be to confer upon industry a continuing advantage at the expense of the general taxpayer.

In effect, the disguised tax referred to in the preceding paragraph means that the overall cost is shared already by the community even though the process of sharing is an indirect one. In the circumstances, it is necessary and fair that the groups that pay now should pay approximately the same amounts as contributions to the new scheme when it supplants the present systems. Accordingly, it is proposed that the present source of premium should supply part of the cost of the new scheme and at about the same overall levels of contribution.

- (b) At present, premiums paid by employers in respect of workers' compensation insurance are assessed on the basis of the degree of risk supposed to be inherent in the industry concerned. For the purpose each industry is regarded as an isolated economic unit—for mining for example there is a much heavier premium than for a service industry such as retailing—the fact that each is an essential component of the general productive effort of the country is ignored. Instead there is a meticulous process of classifying risks and relating premium rates in this manner. In the end, the community pays anyway. In the Commission's view this method of risk classification serves no useful economic purpose and was abandoned in the United Kingdom some time ago and should be abandoned in Australia. It is wasteful in terms of administration and the so-called economic justification for it is illogical.

It may be useful to add the somewhat obvious comment that hazardous industries are not hazardous because the employers in them are less active in the prevention of accidents than other employers, or because the workmen in those industries are less careful than other workmen. For these and other reasons and also because the cost of premiums is such a relatively small part of the cost of production the classification risk cannot be regarded as having any significant chance of contributing to the prevention of accidents. The Commission recommends that the contribution to the new scheme that should be provided by employers should take the form of a uniform National compensation levy based upon the average premium rate for workers' compensation insurance.

The Committee recommends that the average rate of workers' compensation premiums be 2% of salaries and wages.

- (c) In the past, self-employed persons have not been included in the compulsory compensation system. If contributions are to be made to the new scheme related to the earnings and wages of those in employment, then it is necessary to obtain a similar contribution based upon the net earnings of self-employed, since they will now be covered; such payments to be treated as a deduction for income tax purposes in addition to the present deduction permitted for life insurance or for superannuation contributions. Further, in the case of both employers and the self-employed the levy should not be charged against earnings in excess of \$26,000 per annum on the grounds that such a figure represents the ceiling within which earnings related compensation will be paid.
- (d) In recommending a national workmen's compensation levy, the Commission noted that it was not overlooking the fact that at the time this was a state levy. In the Commissioners' view a flat rate levy is needed in substitution for workers' compensation insurance pre-

miums regardless of the fact that the rates for these premiums presently vary from occupation to occupation and state by state. The Commission recommended that once the rate is fixed it should not subsequently be increased. If additional funds should be needed they should be obtained from the consolidated fund through taxation.

- (e) As for the motorist, the Committee recommended that in substitution for motor vehicle third-party insurance the contribution should take the form of an excise tax on gas and diesel fuel used in highway vehicles. The contribution to the fund would therefore vary in direct relation to distance traveled. The Commission recommended a tax of 10¢ a gallon.
- (f) The balance of the cost of the scheme would come from general taxes.

For purposes of its study the Committee developed cost data which in brief indicated:

- (a) The injury part of the compensation scheme, which will match the existing remedies and yet cover injuries occurring in the home, at school, on the highway, at work and everywhere else, will nevertheless cost far less than the amounts required to service the present compulsory insurance schemes which support only some of those who are injured on the highway and those employees who are injured at their place of work.
- (b) All congenital cases can be included in the injury scheme and it will still cost less than the existing compulsory insurance systems.
- (c) The total cost of the scheme for injury, congenital incapacities and sickness as well would involve payments in the order of \$A 500 million per annum more than the amounts at the present required to service two compulsory insurance systems together with existing social provisions that are relevant. Against this amount there would be a setoff in the form of large indirect savings of sick pay and voluntary personal injury insurance. The Commission concluded that the cost of extending the scheme to sickness is within acceptable limits.

D. THE UNITED KINGDOM

In 1973, a Royal Commission on Civil Liberty and Compensation for Personal Injury (the Pearson Commission) under the Chairmanship of Lord Pearson was appointed with the following terms of reference.

“To consider to what extent, in what circumstances and by what means compensation should be payable in respect of death or personal injury (including ante-natal injury) suffered by any person

- (a) In the course of employment;
- (b) Through the use of a motor vehicle or other means of transport;
- (c) Through the manufacture, supply or use of goods or services;
- (d) On premises belonging to or occupied by another; or
- (e) Otherwise through the Act or omission of another where compensation under the present law is recoverable only on proof of fault or under the rules of strict liability,

Having regard to the cost and other implications of the arrangements for the recovery of compensation, whether by way of compulsory insurance or otherwise''.

Before reviewing the finding and recommendations of the Pearson Commission which dealt with accident compensation, a brief summary of health care in the United Kingdom follows:

Health Care in The United Kingdom

In 1944, the government published a white paper—‘‘A National Health Service’’—referring to its primary objectives as follows:

‘‘The government have announced that they intend to establish a comprehensive health service for everybody in this country. They want to ensure that in future

1. Every man, woman and child can rely on getting all the advice and treatment and care which they may need in matters of personal health;
2. That what they get shall be in the best medical and other facilities available;
3. That they are getting these shall not depend on whether they can pay for them, or on any other factor irrelevant to the real need—the real need being to bring the country’s full resources to bear upon reducing ill health and promoting good health in all its citizens’’.

By the time the National Health Services Bill as submitted by the then Labour government received its first reading in March 1946, there had been a shift away from the idea of providing only a basic service and a comprehensive service ‘‘free at the time of need’’ was planned. The Act was passed in November 1946. All voluntary, municipal and Poor Law hospitals were nationalized and hospital medical staff were employed on a salaried basis.

The National Health Services, as created by the 1948 Act, is a comprehensive service covering almost all forms of medical treatments which are freely available to all, irrespective of membership in any insurance scheme. In the main, it is centrally financed by taxation, has no connection with the social security system and its services are not limited to those that contribute to that system. its finances come, apart from a contribution deducted from the wages of the working population, from the general

Exchequer. Contributions from workers constitute considerably less than 10% of the total financing requirements. Where the patient pays at all, it is often only a nominal charge, e.g. prescription charges, though some dental charges are more significant. It is, therefore, a community finance service available to all without means test and mainly without a charge at the time. It is available to all but not compulsorily so. Doctors both in hospitals and general practice are given the right to spend part of their time in private practice and the patient has the right to choose this private treatment, or the National Health Service, at any time.

The National Health Service originally intended to provide services free at the time of consumption to everyone but in certain areas, notably dentistry and pharmaceuticals, this has not been possible. There are important exemptions from payment of both prescription and dental charges for, amongst others, children under age 16, pregnant women and mothers with children under the age of 12 months. The National Health Service has been under-financed almost since its inception. The costs of a comprehensive health service were under-estimated initially and this situation has been aggravated as the demand for treatment has increased, rather than decline as was originally believed would be the case, and the cost of treatment has steadily increased with more sophisticated techniques. This problem has been compounded as the general rate of inflation has been high and staffing costs have risen considerably.

In recent years, there has been a shift in emphasis from hospital to community care, with particular stress on primary care services and those for the elderly, the mentally ill and handicapped, the physically handicapped and children.

It is clear that at the time of the 1948 Act there was acceptance by government and the medical profession of the need for an on-going private sector, both within the National Health Services hospitals and elsewhere.

Private medical treatment may be received either in a private nursing home or as a private patient in the National Health Service hospital. In either case, the patient pays the full cost of accommodation and treatment. Most private treatment is concerned with non-urgent surgery.

Treatment on a private basis may be provided in a variety of ways—by a general practitioner who has no national health service patients or who mixes private and national health service work, and by a consultant who may work either entirely in the private sector or have a part-time contract with the National Health Service. The private sector of medicine is quite small when compared with the number of people covered by the National Health Service.

The Labour government of 1974 onwards was pledged to phase-out private practice from the National Health Service. The government action against private beds in National Health Service hospitals culminated in the

introduction of the Health Services Bill in 1976. This bill was introduced primarily to secure the progressive withdrawal of authorization of all pay beds and facilities used for the private practice of medicine in the National Health Service and secondly to introduce new powers of control over private hospital building. As soon as the measures to phase-out pay beds from the National Health Service hospitals became known, the private sector began to make plans for replacing those beds. An independent hospital group was set up to co-ordinate the provision of private accommodation and facilities for the treatment of acute illnesses on a basis related to need and to the demand from the public and the medical profession over the whole of the U.K. following the phase-out of pay beds from the National Health Service.

The situation changed enormously when the Conservatives won the general election of May 1979. It was part of the Conservative's election manifesto to support actively the private medical sector and to cease the phasing-out of National Health Service pay beds as soon as possible. The government's full plans for the private medical sector and private health insurance are now designed to be more conducive to sustain growth of this section over the next few years than for quite a considerable time past.

Implications of The United Kingdom's Membership in The European Economic Community

A consideration that is important particularly to the private sector insurers and government regulators in the United Kingdom is created by the country's membership in the EEC. All EEC members must reflect in their insurance legislation EEC Directives: the Non-Life Establishment Directive of July 24, 1973 and the Life Directive of March 5, 1979. Health insurance covers both medical expenses insurance and permanent health insurance (long-term disability); medical expenses insurance coming under the Non-Life Directive and permanent health insurance being under the Life Directive.

There are currently discussions in Brussels with regard to a possibility of introducing a Directive specifically on health insurance to overcome a lack of harmonization between countries and several anomalies that exist at present.

The Report of The Royal Commission on Civil Liability and Compensation for Personal Injury (The Pearson Commission)

The terms of reference of the Pearson Commission were noted above. In the introductory portion of its report, the Commission made the following comment:

“The interpretation of our terms of reference was not free from difficulties . . . but the main points are clear. The terms of reference do not cover property damage or any loss not resulting from death or personal injury. They cover injury but, subject to special points, not illness except when it results from injury. Moreover, not all injuries

are covered, but only those within the five categories which are specified, with the result that many injuries, including many suffered in the home, are outside our remit. The terms of reference clearly do not envisage as immediately practicable a comprehensive scheme dealing with all injuries, still less a “universal” scheme dealing with all incapacities whether caused by injury, disease or congenital defect”.

The Commission held its first meeting in March 1973 and held extensive hearings both in the United Kingdom and a number of countries throughout the world. The Commission tabled its report in March 1978. The report consisted of three volumes. Volume I constitutes the main part and includes all of the Commission’s recommendations. Volume II contains information on statistics and costing and the results of a household survey. Volume III contains a summary of the information gathered in connection with the Commission’s overseas visits, supplemented by relevant information obtained from other countries.

In its summary of conclusions, the Commission made the following general comment:

“Our compensation systems should be looked at as a whole.

Tort should be retained and, while the two systems of tort and social security should continue side by side, the relationship between them should be significantly altered. Social security should be recognized as the principal means of compensation. Double compensation should be avoided by offsetting social security benefits in the assessment of tort damages. Money available should be spent on the more serious injuries rather than minor injuries. The range of those receiving compensation should be extended.

No-fault compensation should be introduced for motor vehicle injuries. The no-fault provision for work injuries should be improved. A new benefit for all severely handicapped children should be introduced.

The range of tort should be extended by introducing strict liability in some areas. Under tort, provision should be made for periodic payments for pecuniary loss.

In administering compensation, existing systems and institutions should be used, but considerable simplification of the highly complicated social security system is desirable.

Our terms of reference do not cover all injuries, and at least one million injuries every year, mostly those occurring in the home, would remain outside the scope of our proposals.”

The Commission then went on to make a total of 188 recommendations. The following quotations from the Commission’s report Volume I—Sum-

mary of Conclusions, recapitulates the main feature of the Commission's conclusions and recommendations concerning:

- tort and the assessment of damages;
- work injuries;
- road injuries;
- medical injury;
- ante-natal injury;
- children;
- criminal injuries; and
- the cost of our proposals.

“Tort and the Assessment of Damages”

We conclude that the action of tort, of which there are many criticisms, should nevertheless be retained. Liability in tort should remain a liability in negligence except where there are special reasons for imposing strict liability. We found special reasons for strict liability in respect of products, rail transport, volunteers for medical research, vaccine damage and things and operations involving exceptional risks.

So far as possible, the principle of making full reparation for the loss suffered should be continued. Damages should continue to be awarded for pecuniary loss and non-pecuniary loss, but changes should be made in the method of assessment and in the method of payment. In particular tort damages should be reduced by taking into account the full amount of the social security benefits payable as a result of the injury, thus avoiding double compensation. The number of small claims should be reduced by imposing a threshold for damages for non-pecuniary loss. A system of periodic payments should be introduced for pecuniary loss caused by death or serious and lasting injury, although the parties should still be at liberty to settle a claim for an agreed lump sum. The method of calculating the loss when expressed as a lump sum should take fuller account of the effects of the plaintiff's tax position and of inflation.”

“Work Injuries

We conclude that the industrial injuries scheme administered by Department of Health and Social Services (DHSS) should provide the basis for improved provision for those injured at work. Higher benefits should be paid for the first six months of incapacity or widowhood, followed by pensions calculated in the same way as in the new state pensions scheme, but in all cases at the improved levels that would accrue if contributions to the scheme had been paid for 20 years. Widowers should be treated in the same way as widows. The scheme should be extended to cover the self employed and to include commuting accidents. The conditions for compensation for occupational diseases should be less restrictive. The increased compensation costs should be met by employers.”

“Road Injuries

We conclude that a no-fault compensation scheme should be introduced for injuries caused by motor vehicles, modelled on the scheme we recommend for work injuries with benefits at broadly the same level. Special provision should be made for children and non-earners, including housewives and retirement pensioners. The scheme should be administered by DHSS and should be financed by a levy on petrol.”

“Medical Injury

We conclude that a no-fault scheme for medical accidents should not be introduced at present; but that the progress of no-fault compensation for medical accidents in New Zealand and Sweden should be studied and assessed, so that the experience could be drawn upon, if it was decided to introduce a no-fault scheme for medical accidents in this country. The negligence action could remain. Volunteers for medical research should have a right of action for tort damages based on strict liability.”

“Ante-Natal Injury

We conclude that as the cause of congenital malformation can rarely be established, it is not practicable to identify those cases within our terms of reference and to devise a separate scheme for them. Children who are injured before birth should be considered as part of the problem of compensation for all children who are injured. The tort action provided under the Congenital Disabilities (Civil Liability) Act 1976 should be retained, but its operation should be restricted because there are grave objections to the tort action within the family in the sphere of ante-natal injury. The introduction of strict liability for products would provide a remedy for ante-natal injury caused by ‘defective’ drugs.”

“Children

We conclude that all children who are severely handicapped should be treated in the same way no matter what the cause of their handicap. A special benefit for severely handicapped children should be introduced. As there is no obvious source of finance related to the causes of handicap, the cost should be borne by the Exchequer.”

“The Cost of Our Proposals

As far as possible the cost of compensation should be borne by those creating the risks. Compensation should be redistributed in favour of the seriously injured. By removing double compensation, eliminating tort compensation for trivial injuries and reducing the amount spent on administration the overall cost compensation for personal injury would be reduced in the early years, although ultimately there would be an overall increase of £41 million a year (at January 1977 prices). This change reflects an increase in the cost of social security compensation of £130 million a year and a reduction in the cost of tort compensation and other payments of £89 million a year.”

Some Comments Following Publication of The Pearson Commission Report

The report of the Pearson Commission generated a great deal of discussion not only among regulators and legislators but also insurers, academics, lawyers and other interested parties.

One of the commissioners, Lord Allen of Abbeydale commented:

“Our remit covered a wide field, and I have to say that, speaking for myself, it was only gradually that I fully appreciated how much the various issues we were considering interlocked with each other. By the time we were asked to consider an interim report on a particular aspect, we all of us felt that it simply was not possible to do this and to pull out one thread of the tapestry before we had worked out the overall pattern.”

He then went on to say in reference to the Commission’s conclusions:

“the most important were the proposals for a “no-fault” scheme for motor vehicle accidents, improvements in the industrial injuries scheme, a new benefit for severely handicapped children, new categories of strict liability, provisions for index-linked periodical payments in serious cases, and more realistic methods of calculating lumpsums. But I should like, if I may, to put special emphasis on what we said about the need to look at compensation as a whole, and in particular at the combined effect of tort and social security awards.”

He added:

“I have been involved in a number of discussions on various aspects of compensation, and I find that it is still quite usual for people to talk as though social security is not compensation, in any real sense, at all, and as though “no-fault” would be a complete novelty in this country.”

Another observer C. J. Bourn of the Department of Adult Education of the University of Leicester in referring to the Commission’s terms of reference commented that they:

“encompassed a wide and complex field . . . but which significantly did not cover compensation for every type of accident. In particular, accidents in the home, which account for 30%-40% of all accidental injury, were not covered by the terms of reference.”

He then went on to say:

“The shape of the Report, and its conclusions, reflect the efforts of the Commission to reconcile the operation of two conflicting principles of accident compensation, one based on the attribution of fault to a defendant and the other based upon the needs of the victim irrespective of the reason why his accident occurred, without, by virtue of a terms of reference, being able to recommend a comprehensive scheme of compensation which would cover all accidents whether and however they occurred . . .

In view of the fact that a comprehensive scheme of no-fault compensation was excluded by its terms of reference, the Commission therefore went on to consider the desirability and feasibility of extending no-fault compensation on a case-by-case basis and considering in a similar manner the possible functions of the law of tort in each case. The structure of the Report therefore follows the typical legal division of accidents by the nature of their causation and reviews for each type in turn the application of no-fault and tort as a basis of compensation.”

To accomplish this, the Commission’s recommendations fell into three parts: those intended to co-ordinate the effects of no-fault and the tort system; extensions and improvements to the area of no-fault compensation; and, changes to the pattern of tort liability and damages.

In appraising the Pearson proposals D. R. Harris, Director, Centre for Socio-Legal studies, Oxford University commented:

“The present compensation systems are so open to criticism that it is easy for the Commission to claim that their proposals, taken together, would lead to compensation for injured people being “appreciably improved and extended”. It cannot be denied that the Pearson package or proposal is better than the present position, and that implementation of the Commission’s proposals would be much better than no reform at all: but that comparison should not inhibit criticism of the limited nature of the reforms suggested.

The “mixed system” recommended by the Commission produces an incredibly complex set of methods of compensating injured people.”

Mr. Harris observed further.

“It is not easy to discover any consistent objectives in the Report towards which all its recommendations are aimed. The Commission was obviously dissatisfied with the present position of injured and disabled people and wished to improve their lot, but, with few exceptions, the Report does not consider the disabled population as a whole. It seems that the Commission was dominated by legalistic thinking: it approached the problem of compensation by thinking in categories derived from the previous law on accident compensation, such as work and road accidents, defective products, defective premises, exceptional risks, etc. The legalistic approach of the Commission was largely the result of the legalistic terms of reference given to it, which categorized injured people according to lawyers’ concepts. The Report thus not only perpetuates the traditional advantage given to accident victims over those disabled by illness, and to some accident victims over those in different categories but also excludes large categories of accident victims from consideration, notably home and leisure accidents”.

To quote Mr. Harris further:

“the Commission was sometimes explicitly conscious of “issues of

equity and broad social policy'', but it seemed unable to adopt a clear ultimate objective. I shall examine two possible long-term strategies which it might have adopted: sometimes its proposals are consistent with one, sometimes with the other and sometimes with neither.''

Mr. Harris's two strategies were:

- The first possible ultimate goal: the abolition of the distinction between accidents and sickness as grounds for entitlement to compensation.
- The second possible ultimate goal: a comprehensive scheme for all accidents.

The second possibility might have applied if the Commission had rejected as utopian, at least for the foreseeable future, the goal of ultimately integrating compensation for sickness and disability with that for injuries suffered in accidents.

In an article entitled "What Now?" P. S. Atiyah, Professor of English Law, University of Oxford observed:

"Whether the report of a Royal Commission or Committee of Inquiry is ever implemented often depends in practice on a variety of factors, not wholly-related to the merits of the report itself. But in the case of the Pearson report, one feels—and it may not be premature to say this even now—that full implementation is unlikely, and that it is the character, and indeed the deficiencies of the report itself that make this unlikely.'"

He observed:

"the Pearson report raises difficulties even for the moderate reformer who was willing to settle for half a loaf, and most of these difficulties stem from one basic feature of the report, mainly that it does not appear to be based on any coherent principles of social policy.'"

Later in his article, Mr. Atiyah noted:

"It would, I fear, be idle to suppose that any government would be willing in the immediate future to grasp the nettle that the Royal Commission has itself refused to touch. On the one hand, the complexities of planning a Woodhouse-type scheme, to be detailed into the already over-complex social security system that we have, would require a further five years of study by another high level Commission of Inquiry . . .

Strategic considerations therefore suggest that, while retaining total or almost total abolition of the long-term objective, some form of compromise may have to be accepted for the present.'"

E. FRANCE

Regarding work-related accidents, there is a no-fault work accident insurance scheme covering all people in paid employment. Most are covered

by a general scheme, the remainder, such as government employees and agricultural workers, by special, but similar schemes. The general scheme is financed wholly by employers, with contribution rates fixed annually on experience during the last three years for which statistics are available. Depending on whether the business is categorized as small, large or intermediate, the contributions will be on a national rate, an individual rate or based partly on the national rate and partly on an individually-assessed rate, respectively.

No action in tort may be brought against the employer unless the injury was the result of an intentional act by the employer or a fellow worker, though a third party may be sued. The insurance fund is given a right of subrogation in respect of the cost of benefits provided to the injured person.

Under the scheme, a sum equal to half the average gross daily wage is payable for the first 28 days for temporary disablement entailing incapacity for work; thereafter $\frac{2}{3}$ of that sum is payable until recovery or stabilization of the condition subject to a maximum daily payment. Compensation for permanent disablement is related to the degree of disablement and the gross reckonage earnings in the 12 months preceding the cessation of work, subject both to an earnings maximum and minimum.

The general society security scheme, together with certain special schemes, provides sickness and invalidity benefits for employees and their dependants. The scheme is funded by contributions from both employers and employees. The basic benefit is $\frac{1}{2}$ of earnings within a ceiling and may be followed by an invalidity pension which will be at 50% of the average gross annual earnings of the previous 10 years for total incapacity, and 30% for a loss of at least $\frac{2}{3}$ earning capacity.

Article 1384 of the Civil Code of France establishes vicarious liability for the acts of persons for whom the person in question is responsible, and also for damages caused by things which he had in his custody. This has been interpreted by the courts as reversing the burden of proof, so that the custodian of the article in question has to prove that he was not at fault. The courts have established that an accident which is caused by a car driven by a person is to be regarded as the "act of a thing" within the meaning of article 1384 rather than being the act of a person. It is possible to rebut the presumption of fault, but this can be done only by proof of an unforeseen and unavoidable event which in the case of a car, cannot be imputed to the custodian of the car. It is not enough for the custodian of the car to prove that he did not commit any fault, or that the cause of the damage had not been determined: he will have to show fault on the part of the victim or on the part of a third party or force majeure. This of course is of particular advantage to the victim of a road accident. Reformers have had no success in introducing a no-fault scheme for road injuries in France.

Likewise, the courts have been very sympathetic in their application of sections of the Civil Code as regards compensation for injuries suffered by reasons of defect in a product. Manufacturers and anyone dealing in the chain to the consumer are substantially in the same position as the driver of an automobile, noted above, when it comes to reversing the burden of proof. Essentially, there is a fault system in effect as it applies to products and their uses.

The French accident compensation strategy is therefore based essentially upon the principle of fault. Recognition of the hardship sometimes caused by this principle has led to a certain mitigation of its harshness, through such devices as reversals of the burden of proof and presumptions of awareness and defects which amount to tinkering with the system rather than radical overhauls. In general, overlapping compensation from more than one source is avoided. Although private insurance payments are ignored, the state sickness insurance funds have subrogation rights against tortfeasors; and the accident victim, once he has recovered compensation from social security, may only recover from the tortfeasor the difference between what he has received already and what tort liability will allow him.

In commenting on the system in France, David K. Allen of the University of Leicester commented:

“Although essentially a fault-based system, the emphasis in France may perhaps be said to be on the deterrent element of fault rather than the moral element. This may be evidenced by the maintenance, even in the no-fault work accident insurance scheme, of risk-related contribution rates . . . The recent trend generally seems to be away from fault as a basis for compensation, but the step from there to no-fault in the area such as road injuries is a large one, and there is no immediate prospect of reform.”

F. THE FEDERAL REPUBLIC OF GERMANY

Germany developed the prototype of the social insurance system for industrial injuries which has been copied by so many other countries. The system in Germany today is administered through a number of funds of which the most important are the industrial accident insurance fund and the agricultural fund. An employer is required to join the fund or institute which is most appropriate to the activities of his organization, since most funds are financed entirely by employer's contributions. The employer is required to pay full wages for the first six weeks of incapacity for work. After this time, a temporary benefit is payable on the same basis as sickness benefits i.e. 80% of net earnings, but with a higher earnings ceiling. In the case of sickness, this temporary benefit continues for 78 weeks, after which a pension is payable if the loss of earning capacity is 50% or more: in the case of accidents, the benefit continues to be paid until there is total rehabilitation or it is clear that

the injured person will never recover full working capacity. Thereafter, a pension will be payable at $\frac{2}{3}$ of gross earnings, normally the earnings in the year preceding the accident subject to a maximum earnings level. For partial loss of earning capacity of 20% and above for at least 13 weeks, a percentage of full pension is payable, equivalent to the percentage reduction in earning capacity. Pensions and other periodic allowances are increased annually to keep in line with changes in wage levels.

In determining the rate to be paid by individual firms account is taken not only of the accident experience of the industry in question but also the individual accident record of the firm itself. No action in tort may be brought by a person insured under the federal accident insurance scheme for a work accident unless there has been an intentional act by the employer or a fellow worker which caused the injury.

Beyond the work accidents insurance scheme, compensation for injuries must be sought by proof of fault under the civil code or by reliance on the Road Traffic Act. This latter act imposes strict liability on the owner of a vehicle, though if he can show that an accident was due to an unavoidable event which was caused neither by a mechanical fault nor by the condition of the vehicle and that he or his driver had shown the care of a skilled driver he can avoid liability. Contributory negligence may be taken into account. There are maximums set under the act for lump-sum payments or settlements by way of annuity. These damages do not include compensation for pain and suffering or aesthetic loss and hence questions of fault often have to be adjudicated since an action under the act does not preclude a suit under the civil code.

Generally speaking, the German strategy is a mixed one, based on fault but where it is deemed necessary separate schemes have been created to cover particular types of accidents for which, for whatever reason, tort is considered to be insufficient.

G. SWEDEN

As early as 1950, a committee of experts from Sweden, Norway and Denmark recommended the ultimate replacement of tort liability by social insurance. Sweden is some distance from this goal but the effective replacement of most tort liability for personal injury by no-fault schemes has been significant.

By way of background, the Tort Liability Act sets out the law concerning liability for personal injury in Sweden and requires a person causing personal injury intentionally or through negligence to compensate the person injured. Damages may be reduced by the intentional or grossly negligent act on the part of the injured person. Awards made for loss of earnings under tort will have social insurance payments, employer's sick-pay and payments under the employer's no-fault insurance scheme deducted from them.

The Tort Liability Act does not cover liability for injuries suffered in road accidents. Personal injury claims as the result of road accidents are governed by the Traffic Damage Act. This Act primarily designed to provide compensation for the negligent driver who was injured in a road accident, created a no-fault scheme of compensation based on compulsory insurance with claims being made on a first-party basis directly against the insurer. Contributory negligence may reduce damages if it constitutes gross negligence or if the driver is drunk and found negligent. Though tort is not barred, since compensation is assessed on the same principles as tort damages, future tort action is unlikely. This is the only no-fault road injury scheme in existence in Europe and it is a very complete one.

As regards work injuries the scheme in force is financed entirely by employers, without regard to risk, and provides compensation and medical care after 90 days of incapacity, until recovery or certification of permanent disability. Care and compensation during the first 90 days are provided by the general sickness insurance scheme. The benefits under both of these schemes are linked to the cost of living index and amount to 90% of gross earned income subject to both a minimum and a maximum per year. An earnings-related disability pension is payable for permanent disability of 10% or more. Tort actions may be brought, but they are subject to a deduction for all social security benefits. Tort actions are likely to be very rare because of a general agreement between unions and employers covering most of the working population, whereby the employers have agreed to provide no-fault compensation to employees injured at work or traveling to or from work or suffering from an occupational disease for more than 90 days. This scheme is funded by private insurance with the premiums paid wholly by the employers. Basically, this scheme provides the 10% of compensation not covered by the social security benefits of 90% of compensation due.

The terms of the agreement prevent an employee from suing his employer. Incapacity must have lasted for more than seven days: the compensation payable for the first 30 days is geared to meet full pecuniary loss. After 30 days, cases are dealt with on an individual basis. Compensation, as a lump-sum, is payable for pain and suffering when incapacity lasts for more than 30 days. Compensation may also be made for permanent disfigurement, loss of amenities and ability to enjoy life.

In effect, for the most frequently occurring accidents, tort action is redundant although not abolished in Sweden. The compensation payable to victims of road and work accidents is both generous and comprehensive and as a consequence there is very little point in bringing a tort action. It is intended that the no-fault compensation concept will be expanded to cover victims of medical accidents. In addition, there is under consideration a scheme designed to compensate persons injured by the use of medicine to be funded by compulsory premiums which would be paid by producers of

pharmaceutical products and importers of medicines manufactured by foreign companies. This too would be a no-fault scheme.

The scheme in effect in Sweden is not as comprehensive as that in New Zealand; however, there is no-fault liability for a large number of accidents in Sweden. Nevertheless, the plan has not the overall scope of the New Zealand system and does not cover for example accidents in the home and liability for products other than pharmaceuticals. Further each of the various schemes in Sweden are administered separately. In addition since compensation may be payable from different schemes, one scheme will give greater compensation to a person injured at work, than at home.

H. THE NETHERLANDS

An unique feature of the Netherlands system of general social security is the absence of special provisions for industrial injury or disease. Socio-political thinking in the Netherlands has gradually evolved from the position that it is not the cause i.e. personal injury or sickness, which requires compensation, but rather its consequential loss of earning capacity. The Workers Loss of Earning Capacity Act covers all employed persons incapable of working, regardless of the cause of their incapacity.

Another law, the National Act on Loss of Earning Capacity, has been in operation for a shorter period of time and covers among others, the self-employed. The philosophy underlying this piece of legislation is that during a short period of incapacity for work, the self-employed do not run the same risk as wage-earners because in many cases they are capable of continuing their business or occupation temporarily by arranging for assistance. If incapacity for work becomes prolonged, however, the problems of the self-employed tend to be just as serious as for wage earners and the more recent legislation seeks to meet this problem.

A Sickness Benefit Act covers all employed persons except a few classes of employees who have their own special scheme of sickness insurance. There is compulsory insurance without an earnings limit but contributions and benefit rates are calculated on the basis of maximum earnings. Within this limit, sickness benefit is 80% of gross earnings immediately before incapacity. Benefits are payable for up to 52 weeks, longer for tuberculosis and certain other specified diseases. Contributions, which also cover maternity benefits, are fixed by an administrative board for the occupations within its membership according to illness and accident risk. Contributions are made by both employer and employee with a much more significant amount being contributed by employers. The extent of incapacity of an injured person is decided by the Joint Medical Service administered by a board of ten members made up equally of employer and employee representatives.

All public service and practically all of the working population are also

covered by negotiated occupational schemes regarding sickness. These guarantee levels of benefits whether or not caused by injury or disease above those of the general schemes and usually make up 100% of earnings for the first year.

If at the end of 52 weeks or three years in the case of certain special diseases, a person is still incapacitated to the extent of 15% or more, benefits will be paid under the Workers Loss of Earning Capacity Act. No benefits are paid for incapacity of less than 15%. Benefits for incapacity over 15% increase with the degree of severity until 80% of gross earnings is paid. Earnings are based on those the injured person would have earned within the insurable ceiling in his former occupation. Benefits are not increased in respect of dependent children; these are covered by the general family allowance scheme. At the age of 65, benefits are replaced by the old-age pension.

Contributions under the Workers Loss of Earning Capacity Act are made by both employers and employees. Under a 1976 amendment to this latter act, all residents of the Netherlands, with the exception of married women, aged 18 or over who have been incapacitated for a prolonged period by at least 25% are entitled to a pension. Married women are excluded from the full scope of the Act. Married women who are working continue to be fully covered by the Workers Loss of Earning Capacity Act and studies commenced in 1977 to consider the position of married women within the entire framework of social security have not been obtained.

All social security benefits with the exception of family allowances are subject to income taxes.

The Health Insurance Act provides for medical, dental and hospital care for up to one year, including the provision of medicines and appliances, for all employed persons whose earnings are not more than a defined minimum. The cover extends to the unemployed, old age pensioners, non-working wives and dependent children. Voluntary insurance is allowed under the Act and altogether a substantial percentage of the population are covered. Contributions are collected by the industrial insurance boards with employer and employees each paying a percent of defined earnings.

Under the Health Insurance Act, an insured person is free to choose his or her doctor and all financial transactions are direct between the doctor and the health insurance fund. Similarly the costs of prescribed medicines is settled directly between the pharmacist and the fund since no charge is made under the Act for hospital treatment which lasts up to one year. Where treatment extends beyond one year, the provisions of another Act comes into force which requires that part of the costs of the treatment according to income level must be paid in some cases since contributions are collected by way of a surcharge on income tax at a percent of earnings up to a maximum yearly

earning figure. The balance of costs of looking after long-term hospital treatment comes from general revenues.

There are survivor benefits for widows and orphans at stipulated annual rates. Under the act governing this particular benefit, compulsory contributions are paid by the insured person at a prescribed rate of earnings with an income ceiling. A death grant is payable equal to the deceased's full wages for the remainder of the month of death and the next two months.

All benefit rates are adjusted on January 1 and July 1 each year in accordance with the wage index of October 30 and April 30 respectively.

Overall responsibility for rehabilitation services rests with the government. General rehabilitation centres are normally attached to hospitals. Disabled can obtain such aids as invalid cars, study expenses, and alterations to the home to facilitate mobility through funds provided under the National Act on Loss of Earning Capacity.

I. SWITZERLAND

In Volume III of its report, the Pearson Commission noted in commenting on Switzerland:

“Compensation for personal injury in Switzerland is based primarily on that part of the civil law known as the code of obligations. In some respects social security cover is more limited than in most Western European countries, but where a worker comes within the statutory work accident scheme, he is also covered for compensation for personal injury arising from accidents outside work. Special legislation in respect of road traffic accidents imposes strict liability on the “keeper” of a motor vehicle, and claims in respect of personal injury may be made directly against the insurers”.

As regards medical care and sickness benefits, benefits for temporary illness are based on federal Swiss law, but differ in detail between cantons: some are compulsory and most are restricted to those whose income are below a specified limit. Voluntary insurance is extensive and most residents of the country are covered in varying degrees. There are special federal provisions to ensure that medical care is available for children suffering from congenital disabilities. In matters relating to work injuries, a significant portion of the work force are also insured under compulsory coverage under a federal scheme of work accident insurance. The plan covers those in factories, the construction industry, transport and certain specified high risk occupations; there are special schemes for agricultural workers and certain other occupations. The self-employed are not covered under this scheme and can secure coverage only by private insurance. A 1977 Bill included provisions for the extension of coverage to all employees, and for the acceptance of disease as occupational in origin which are not included in an existing schedule of such diseases.

Benefits under the work accident scheme are related to the injured person's gross earnings during the last year before the accident with an upper limit on these earnings for purposes of calculation. Temporary benefits are paid equal to 80% of earnings until recovery or confirmation of permanent disability. For total permanent disablement, the benefit rate is 70% of earnings with possible upward adjustment from this percentage in some cases. For partial incapacity, awards take into account both the medical degree of disability and both pre- and post-accident earnings. Benefits are subject to review and can be increased, reduced or terminated. Medical care is provided without charge for the injured person.

Under the work accident plan, widows irrespective of age at widowhood, receive a pension at the rate of 30% of the deceased husband's earnings, a dependent child 15% and an orphan 25%.

The entire work accident insurance cost is met by employers. Contributions are based on the accident experience both of the industry and of the individual undertaking. One business can be rated differently for different categories of workers. The workers within the scheme are also covered for similar benefits in respect of personal injury resulting from an accident unconnected with work. For this coverage, workers are required to contribute a percentage of their earnings.

Benefits of both the general social security plan and a work accident scheme are subject to income tax. Benefits are increased at least in line with the cost of living index.

Swiss law requires every employer to take appropriate safety precautions. These are supervised by state factory inspectors and the agency also has its own engineering inspectors.

Regarding road injuries, the Motor Traffic Law provides for strict liability on the part of the "keeper", usually the owner, for damages caused by a motor vehicle. The law also requires compulsory liability insurance for each vehicle. The keeper of a motor vehicle can exonerate himself if he can establish that the accident was caused by force majeure or gross negligence on the part of the victim or a third party; that neither he nor any other person for whose conduct he was responsible was at fault; and that no defect in the vehicle contributed to the accident. Where there is contributory negligence, the court is empowered to determine damages appropriately. Both pecuniary and non-pecuniary losses are compensated. The code gives the courts discretion to award either a lump sum or periodic payments. Normally, a lump-sum is preferred.

J. THE UNITED STATES

The United States has no universal health insurance protection program. The Medicare scheme, enacted in 1965, provides protection for the old and

the disabled who are entitled to benefits under social security and railroad retirement programs. Hospital and doctors fees are covered by the hospital insurance and supplementary medical insurance program respectively. Citizens of the United States make widespread use of private insurance programs to cover health service costs other than those provided under the state programs. There is also widespread use of private insurance plans to cover loss of income.

Compensation for road accident injuries in the U.S. varies from state to state and is quite complex. During the 1920's, a number of states passed "financial responsibility laws" that did not require a driver to have a liability insurance policy until he was involved in an accident causing personal injury or damage to property above a statutory minimum, or was convicted of a serious driving offense. The requirement was that in the event of one of these happenings the driver had to prove that he had a liability insurance policy to cover future accidents up to this statutory amount. Later, states began to require coverage for liability in the instant accident. Instead of financial responsibility laws, some states passed laws requiring compulsory tort liability insurance.

There has been increasing pressure over the years for some form of no-fault insurance which in one form or another has been adopted by about half of the states. There is a great variety in approaches and levels of compensation in the schemes. There are three fundamental types of plans. First, there are "add-on plans" which add no-fault benefits to the existing motor vehicle liability insurance policy leaving the right to sue in tort intact, except that under some schemes damages recovered in tort may be reduced by the amount of no-fault benefits paid. Secondly, there are "modified plans" which partially eliminate tort either to the extent that no-fault rights are available, or by removing the right to sue for non-pecuniary loss in minor injury cases. Finally, there are "plans approaching pure no-fault" which come close to total no-fault and no tort. Pain and suffering are sometimes compensated in full; in some states though, there are limitations.

Workmen's compensation is covered by a no-fault Workmen's Compensation Act in each state. No state has an all inclusive plan; for example, farm work, domestic service and casual work are often excluded and many state laws are elective; thus the employer may choose to reject the no-fault law and be sued in tort, but if he chooses the latter, he loses the protection of his common law defenses—contributory negligence, assumption of risk, etc. Typically most state schemes call for a short waiting period, non-taxable benefit payments, usually with a maximum for temporary or permanent total disability of $\frac{2}{3}$ of gross wages subject to maxima and minima. Provisions are also made for medical care and rehabilitation. The injury must be one that results from an accident arising out of and in the course of employment.

Workers' compensation in the United States is mainly privately ad-

ministered and funded, with a statutory duty on the employer to pay benefits. Self-insurance is usually permitted. For employers who take out private insurance, there is experience-rating done by class for most employers although some large employers are individually rated. Claims are usually supervised by either the Labour Department or in some cases by a separate administrative body.

By most standards, the social security benefits in the United States are less extensive than those in most other western countries. Contributions from employers and employees finance the disability benefits which are payable to disabled workers and their dependents for loss of earnings due to long-term disability. Payments of benefits for a disabled worker together with workers' compensation received may not exceed 80% of the worker's former wage.

Regarding compensation of accident victims in the area of products liability, the original basis of liability is negligence. Strict liability was imposed, first through express contractual warranties, and then by means of the doctrine of implied warranty. Liability is generally strict rather than absolute; thus there may be defenses of, for example, contributory negligence, assumption of risk, and abnormal use. The breadth and complexity of the extension of products liability has caused anxiety among manufacturers and insurers and there have been a number of investigations of various factors as causing problems. In July 1978, the Secretary of Commerce announced that the Administration had directed that a model uniform product liability law be prepared which would be enacted by each of the states. It was also recommended that workers' compensation should be the sole source of recovery for employees suffering products-related injuries at the work place.

There is no evidence of any move away from private insurance towards state insurance as the basis for compensation payments in the United States, though it has been suggested by some that since medical expenses constitute approximately 80% of all tort claims, any move towards a more extensive national health insurance scheme with assumption of a refusal to allow overlapping compensation, may cause tort actions to become redundant in a number of instances. In the United States, compensation for accident victims is generally regarded in a different light from that prevailing in other western countries. It is predominately the business of the citizen to insure himself against his own losses and against his liability to compensate others.

K. GENERAL COMMENTS REGARDING ALTERNATIVE SCHEMES IN OTHER COUNTRIES

Tort liability, as a basis for accident compensation plays a significant role in most countries of the world, with the exception of New Zealand. In various ways, each country has found it necessary to replace or supplement tort in relation to certain categories of accident, particularly in relation to work accidents, though increasingly tort is being seen as an unsatisfactory

device for the compensation of road accident victims. There is no uniformity of approach in any of these countries to the inter-relation of accident compensation sources or to the role that insurance plays, the choice between private or state schemes, the extent to which conditions are risk-related, or the circumstances in which insurance should be permitted or required at all.

It would seem that the reasons for selecting a particular category of an accident as meriting the compensation on a more automatic basis than on a fault-base system are basically those of the frequency with which such accidents occur. Beyond this, the question of similar compensation for the victims of accidents in the home and ultimately, compensation for victims of all accidents and sickness irrespective of cause, is one that very few countries have developed.

CHAPTER 19

Proposals for Alternative Systems In Saskatchewan and Manitoba

A. INTRODUCTION

The Governments of both the provinces of Saskatchewan and Manitoba have carried out studies and been involved in giving detailed consideration to alternatives to the existing system of financial protection for their citizens in the case of sickness and disability.

Since the implications of the federal system on the deliberations in these provinces is the same as faced by Ontario and the general environment for consideration of accident and sickness financial protection has many similarities with this Province, it is useful to review the alternatives they have been considering.

B. SASKATCHEWAN

The Government of the Province of Saskatchewan and, in particular, the Minister of Labour and the staff in his Department have devoted considerable attention to the matter of accident and sickness coverage for the residents of Saskatchewan in recent years. Among other studies, a Sickness and Accident Insurance Committee under the chairmanship of Harold W. Pope, retired judge of the district court of the Province of Saskatchewan, was appointed in November 1974:

“ . . . to inquire into, investigate, receive representations upon and report on the following:

- (a) The nature and extent of the problem that exists because many persons who suffer injury or illness are not adequately compensated or covered by existing programs;
- (b) The steps that the government should take in response to that problem;
- (c) In the event that a new program is recommended:
 - i. The relationship that should exist between the new program and existing programs;
 - ii. The manner in which the new program should be financed;
 - iii. The projection of the cost of the new program;
 - iv. The method of administration of the new program; and
- (d) Such other areas as the Committee may decide to study.”

The Committee reported to the Minister of Labour on September 1, 1976. During its review, the Committee had examined the existing programs—federal, provincial, and private—including programs regarding workers compensation, automobile insurance, crimes compensation, unemployment

insurance sickness benefits, Canada Pension Plan benefits, coverage available from private insurers, and others. The Committee concluded that the existing coverage is “fragmented, inconsistent and inadequate”.

Before making its recommendations, the Committee explained its basic belief “that the responsibility for the sick and the injured belongs to society; as such, it is society’s responsibility through its government to operate any new program established to deal with the problems of the sick and the injured.”

More specifically, the Committee then turned its attention to the existing workers’ compensation and automobile insurance programs in the Province. Essentially, the Committee believed that both of these programs met its requirements of an equitable compensation system. However, they had recommendations for improvements in each. In the case of workers’ compensation, among other matters, the Committee recommended that all wage and salary earners be brought under the Act; benefit levels be increased; awards should be separated into an income replacement component and a disability component; payments under the income replacement section would be reduced by Canada Pension Plan payments; flat rate death benefits to be replaced by a payment of 80% of the deceased spouse’s net income for five years after which there would be revision to a flat rate; income replacement be linked to cost of living increases; and, past pensions be increased.

Regarding automobile insurance the Committee recommended no-fault coverage as it pertains to personal injury with the level of benefits, duration of benefits and death benefits being the same as under workers’ compensation.

The Committee also recommended a third program for all victims of non-work and non-automobile accidents. The benefits are to be similar to those under the other two plans. The Committee concluded that the right of action in tort in cases of accidents should be debated further although the Committee itself questioned its retention. Given the retention of liability law, the Committee suggested that the new program be somewhat lower than under the other two. The administration of a new program it was recommended, should be in the hands of the government.

In response to the question of the cost implications of any of its recommendations, the Committee indicated that the changes in workers’ compensation could be effected with no appreciable increase in costs. The changes for automobile insurance would result in a 6% increase over present expenditures and it recommended increasing premiums or increasing the transfer of gasoline tax to cover this increase. The costs of the new program were estimated at approximately \$42 million, approximately \$18 million of which would be offset against payments on private sickness and accident insurance which would no longer be required and it was suggested that employers bear the initial cost, estimated at \$7 million, of a short-term plan.

The Committee suggested an increase in personal income taxes or a special levy on employers and employees as a method of financing the balance.

The Committee summarized the highlights of its report as follows:

- Workers' compensation to remain a major program with recommendations for major changes.
- Automobile insurance to remain a major program with major changes including no-fault coverage.
- A new program to be established along the lines of the other two with slightly reduced benefits.
- Crimes compensation and unemployment insurance sickness benefits to become redundant, as does most private insurance coverage.
- Recommendation for integration of benefits with those paid by federal programs.
- The eventual amalgamation of all three programs, each having equal benefits, under one authority."

Little was done with the Pope report in 1977 and 1978 and as a consequence much of the momentum towards a comprehensive program was lost. During this period, efforts were channeled primarily to matters relating to workers' compensation. Another report was prepared relating to workers' compensation and it became the preoccupation of the Ministry of Labour. As it related to the theme of sickness and accident insurance, the concepts of the amended program were briefly as follows:

- Benefit entitlement was to be made proportionate to loss of earnings using a rate of 75%.
- Benefits under workers' compensation would cease at age 65 with payment of disability retirement benefits.
- Modest lump-sum payments with a maximum of \$10,000 would be paid for those that were killed or severely maimed with proportionate lesser percentage payments paid for less severe losses.

The government enacted these concepts in 1979.

The enactment of the changes in the workers' compensation plan gave the Department of Labour new incentive to start thinking again about disability insurance. While much work has been done, it is understood that draft legislation is not yet ready. In its studies, the staff of the Department of Labour are devoting attention to the following major considerations:

- The entire universe of causal circumstances of accident and sickness —work-related, related to automobile mishaps and all other, including events that take place in the home, at recreation, etc.
- The breadth of contingencies that need to be considered and whether separate consideration should be given to accidents and/or sickness.

- Who would be covered—earners, self-employed, farmers, students, homemakers, those already injured, etc.
- The entire matter of the level of benefits.
- The allocation of costs and the portions which should be borne by—employers, employees, drivers, owners, etc. and the proportion that should be financed by the general revenues of the government.
- The appropriate methods of funding the plans.
- The entire subject of integration of plans—provincial, federal and private.
- The legislative fiat and whether the public and private sector can work together on a comprehensive program such as is envisaged. In this connection, the staff is considering the various alternatives of solely private; the CAASI—voluntary plan; the CAASI—compulsory plan; a mixed public/private plan; and an exclusively public plan.

Throughout its deliberations, the staff of the Department of Labour of the Province of Saskatchewan have concluded that the New Zealand scheme is appropriate only for a country as a whole and not for a Province of Canada. Therefore, the importance of integration of any eventual provincial plan with federal programs must be a major consideration to the staff.

C. MANITOBA

In May of 1977, a white paper on accident and sickness compensation in Manitoba was presented supported by two volumes containing background papers and digests of statistics. The thrust of the white paper and supporting information was much the same as that of the Pope Commission in Saskatchewan. Again, the white paper reviewed existing compensation programs—federal, provincial and private and then dealt with the adequacy or rather the inadequacy of the present protection “system”. Finally, the white paper and supporting volumes reviewed the compensation programs in force in several countries that provide more comprehensive coverage, and more advanced and integrated disability compensation schemes than are now available in Canada.

The white paper noted that:

“The overall objective of an adequate accident and sickness compensation system is to alleviate hardships arising from disability. An adequate system will meet five basic criteria: community responsibility, comprehensive entitlement, complete rehabilitation, real compensation and administrative efficiency.”

These are the same tests of adequacy as articulated by Justice Woodhouse in both New Zealand and Australia in reports of commissions of inquiry of which he was chairman.

In the white paper, the government then went on to recommend:

“Consideration of the responsible development, over time and in stages, of an adequate, universal and comprehensive disability compensation system which meets these criteria. In the short term, due to the fiscal constraints of the current context, . . . concentrate on the major gaps and inadequacies in coverage for accident victims. We recommend consideration of the implementation in the near future of a Supplementary Accident Compensation Program to fill the gap between Workers’ Compensation coverage and Autopac’s motor vehicle accident coverage. Whether or not, or to what extent, the initial program should cover non-earners is an issue on which we actively solicit public opinion.”

In dealing with the more specific aspect of its recommendations concerning a supplementary accident compensation program, the government indicated its current thinking regarding each of the following matters:

- Coverage—All earners should be covered; i.e., all wage and salaried employees and all self-employed persons. Both full and part-time earners should be covered. It should protect all eligible persons against hardships from non-work related and non-motor vehicle related accidents wherever they occur. Accident injuries should be defined generally, and by explicit listing of events to be included.
- Type of benefits—the program should provide for:
 - “— all reasonable medical expenses, including those related to physical rehabilitation, which are not now covered by insured health services or otherwise; —earnings related compensation to replace actual earnings losses;
 - special damages, including such items as necessary or additional transportation expenses; the costs to modify accommodation, place of employment, and/or a motor vehicle; necessary appliances or fixtures not otherwise covered; other special care or services; and
 - rehabilitation cost required in order for the injured person to return to productive employment.”
- Earnings-related compensation at a percent of actual lost net earnings for both temporary and permanent disabilities and for temporary partial disabilities. Net earnings are to be calculated to approximate as closely as possible actual personal disposable income, assuming that compensation payments are not taxable. It is proposed that the maximum allowable compensation level would be related to the average industrial wage.

It is not the intent of the proposal to duplicate or replace existing programs with the proposed new benefit plan. Therefore, the

supplementary accident compensation benefits would be paid only after all other benefits to which a claimant is entitled had been utilized. There would be a general waiting period of 17 weeks equivalent to the unemployment insurance illness benefit combined waiting and benefit period. It would be proposed to discontinue compensation payments at age 65. It was the government's view that it would be desirable to index benefits but it recognized that this might not be practical to implement initially and it might be necessary to make adjustment from time to time by legislative enactment.

- Non-earners—As noted, the government solicited further discussion on the subject of non-earner coverage—reference was made to non-earners recently unemployed, homemakers and child care expense with reference to various difficult administrative and policy questions.
- Integration with other programs—all other public benefits received as a result of an accident should be deducted from compensation payable under the supplementary accident compensation program. Disability benefits from private measures would not be deducted from the supplementary accident compensation payments unless total entitlement exceeded the injured person's previous disposable income.
Introduction of the program would not affect the existence of the common law right to sue for negligence.
- Financing—No specific recommendation was made concerning the method of financing the supplementary program—the various options only were outlined.
- Administration—the supplementary accident compensation program would be a government administered program.
- Cost estimates—with the various options contained in the proposal an estimate only of the cost of the earner's portion of the program was made of \$8 million, net new expenditures if it were in operation in 1977.

At the conclusion of Chapter I of the white paper, the following comment was made:

“The longer-term objective is adequate, universal and comprehensive compensation covering all disabilities regardless of cause. Progress toward this objective will take place over several years as discreet, manageable program phases are defined, evaluated, implemented and integrated into on-going activities. Possible future phases include: improving benefits, program standardization and integration, coverage for all permanent disabilities and “greater hardship” sickness

coverage. As well, the role of the negligence action might be reviewed, and rehabilitation programming further developed.”

The government which prepared the white paper was defeated in the election of October 1977. The Committee understands that certain philosophical considerations and fiscal constraints have led the present government to defer consideration of the implementation of a Supplementary Accident Compensation Program along the lines proposed in the white paper, at least for the time being.

PART V

PREPAID LEGAL SERVICES IN CANADA

CHAPTER 20

An Overview

A. INTRODUCTION

The concept of prepaid legal services is a new one in Canada. There has been much discussion of the concept among employee associations, labour unions, insurance companies, lawyers and bar associations. Prepaid legal service plans can be characterized as an innovative system for delivering legal services to those individuals in our society who, for various economic and social reasons, could not avail themselves of their right to the legal services they require. A prepaid legal services plan would allow an individual client to pay in advance for legal services which he may need to use in the future.

In recent years there has been a dramatic growth of prepaid legal service plans in the United States. It has been argued that the movement toward prepaid legal services is a direct effort by the American people to make "equal justice under law" a reality by obtaining access to high quality legal services at a moderate cost. Canadians have a similar notion of "equality before the law" and, in this instance, the experience in the United States, in the opinion of some, addresses issues which are relevant to the Canadian debate about access to justice. In discussing the importance of access to justice in the United States one critic noted:

"If the service involved were of a lesser magnitude than that of access to legal rights the problem would hardly be as critical. But where the issue involves trafficking in the social and political fabric of our nation, namely a citizen's ability to exercise and protect his rights, the suggestion that the legal system is presently failing vast numbers . . . is not merely a criticism of the legal profession, but is also an indictment of society's inability, to make meaningful the principle of equal justice under law."¹

In 1973, the Canadian Bar Association authorized a study into the demands for prepaid legal service plans in Canada; however, in light of the many surveys conducted in the United States, the study was abandoned as it was felt that substantial data were already available.

A survey carried out by the American Bar Association in 1971 revealed that about 10% of the U.S. public are wealthy enough to bear the full expense of legal services and that about 20% of the population is too poor to bear any expense and therefore qualifies for legal aid. These 1971 survey results indicated to some that there was a class of "unrepresented" Americans numbering almost 70% of the total population that could likely afford only

1 Bernstein, "Legal Services as a Social-Political Movement" (1973), 4 University of Toledo L. Rev. 423.

limited access to legal services. A further survey commissioned by the American Bar Association concluded that the vast majority of middle income Americans were not receiving effective legal representation.

The Canadian Bar Association concluded that there did not appear to be any significant factors in the composition of the Canadian population or the structure of the Canadian legal system which would greatly alter the situation in Canada. Robert G. Smethurst, QC, Chairman of the Canadian Bar Association's Special Committee on Prepaid Legal Services has suggested that we face exactly the same problem:

“Historically, legal service always have been available to our citizens, but in large measure, until the last thirty years or so, only the business community and the wealthier segment of our population have availed themselves of these services. There have been exceptions, of course, such as automobile accident cases, Workmen's compensation, and the like, but until the introduction of free legal aid to indigent persons by the many Law Societies across Canada, the vast majority of our population never retained the services of a lawyer. In fact, that is still the situation today, even with the rapid expansion of free legal aid services in both criminal and civil matters, and in spite of the tremendous amount of publicity given to these plans. It is estimated that between 70% and 75% of our population have not retained the services of lawyers. The greater majority of these are in the middle income group, who, for our purposes, are those earning between \$4,000.00 and \$12,000.00 per year.

To make legal services more accessible and available to a large portion of our population, better systems of delivering these services are definitely needed. One such system is the prepaid legal services plan.”¹

For most Canadians, the services of lawyers would typically be required only for routine transactions such as the purchase of real estate or the drafting of a will.

Besides the matter of cost, the Committee was told there are a number of other factors that have probably limited the potential effectiveness of traditional systems for delivering legal services. Foremost, there is the general public's attitude toward the legal profession. Canadians have been said to have a stereotyped image of lawyers and the legal system. Many people believe that the legal system appears to favor the rich and powerful to the exclusion of the rights and needs of the average man. Such people avoid contact with the legal system and its officers except in cases of urgency or absolute necessity. Many people are often ignorant of their legal rights and remedies and frequently encounter difficulty in finding a lawyer. The brief

¹ Smethurst, R., QC, “Prepaid Legal Services” (1972), 20 Chitty's L.R. 303

submitted to the Committee also noted that most people simply do not know when they have a legal problem. Attempts at public education have not achieved the anticipated results. Even when individuals recognize a legal problem, they often do not know where to find a lawyer to represent them.

B. THE CANADIAN EXPERIENCE

The American insurers have developed a fairly sophisticated network of prepaid legal service plans. It is, therefore, somewhat surprising that the concept is so new in Canada, since it would seem the legal needs of Canadians are probably very similar to those of residents of the United States.

There has been some discussion of this matter in Canada, promoted largely by a group of lawyers, academics and laymen who have formed an organization known as the "Prepaid Legal Services Program of Canada" under the auspices of the Faculty of Law at the University of Windsor, Ontario. The main thrust of the discussion has centred on the regulatory and legislative aspects of providing prepaid legal services.

In 1980, there were three general insurance companies offering prepaid legal services in Canada—the Co-operators Group Ltd. of Guelph and Regina; Gestas Ltd. of Montreal; and Citadel General Assurance Co. of Toronto. Co-operators and Citadel offer group programs while Gestas offers both group and individual plans.

Co-operators has underwritten a prepaid legal service plan for employees and retired employees of United Grain Growers Ltd. A brief description of this plan appeared in an issue of Canadian Underwriter. The plan was described as follows:

"United Grain Growers has a basic plan and a comprehensive plan. The basic plan offers: consultation with a lawyer up to \$20 per visit and a maximum of \$80 per year; preparation and/or review of wills; and, to a maximum of \$240 per year, conveyance of a residence. This benefit includes searching title; preparing transfer or agreement-to-sell documents; attendances at land-title offices; examination of survey certificates; obtaining tax certificates; examining insurance policies; registering documents; discharging encumbrances; disbursing funds and other collateral services, including the preparation and registration of any collateral security.

The comprehensive plan includes the coverage provided under the basic plan; motor vehicle and traffic violations arising under provincial legislation; Criminal Code violations for defence of personal infractions including pre-trial conferences, attendance at bail hearings and court appearances costing up to a maximum of \$350 for summary conviction offences and \$750 for indictable offences; family relations

including separations, divorce, adoption or custody proceedings; and a category designated as meritorious instances. In this category, subject to prior approval by the insurance company, the plan will pay the legal costs, up to a maximum of \$750, where there is a good cause for action and all other avenues of redress have been pursued and exhausted. This will include representation to quasi-judicial or government agencies, and matters concerning employer-employee regulations and consumer protection.

The plan specifies a number of exclusions; the insurance policy does not cover charges incurred for or caused or contributed by the following 14 situations:

- legal services provided to an insured member in regard to any matter arising out of any business interest, business transaction, business pursuit, profession, partnership or corporation for which the annual income to the insured from such business or profession in the current year or in the previous year exceeded \$250;

- any controversy between the insured member and the insurance company or the policyholder relating to benefits payable by the policy;

- actions in which the date of a pending legal matter or the event out of which a legal matter arises precedes the effective date of the insured member's coverage;

- disputes between two or more insured members under the policy in which the interest of the employee's dependents under the coverage is opposed to the insured employee in such a case, coverage will be provided for the insured employee only;

- class actions, interventions and amicus curiae (friend of the court) filings;

- preparation, completion or filing of federal, provincial, or municipal tax returns;

- matters relating to probate, patents, or copy rights;

- any actions brought in small claims court;

- duplication of services previously claimed and in relation to the same subject matter;

- finances, assessments, court costs, penalties or punitive damages;

- any legal proceeding in which the insured member is entitled to a legal representation, or reimbursement for the costs thereof, from any source other than the policy coverage whether or not the insured member exercises this right;

- contingent fee cases where there is some form of continuous service;

expenses recoverable from a third party;
war or an act of war or participation in a riot or civil insurrection.”¹

C. EXPERIENCE IN OTHER JURISDICTIONS

United States

Plans of prepaid legal services date back to as early as 1899 in the United States. Participation in these plans was related to membership in a group or related to employment of the individual. For example, a teacher could be assisted with legal representation for dismissal or suspension from employment or legal actions arising from injuries suffered on the job.

The first American plan that offered substantial coverage for personal legal problems to the worker was the Shreveport plan of legal services which began in January 1971. Under that plan a union member had 3¢ per hour of his union dues placed in a legal services trust fund which gave the individual a potential of almost \$3,000 worth in legal services for the year. The services covered by the plan included consultation, office work and representation on judicial or administrative procedures. Since the Shreveport plan, a number of other plans have become popular in the United States. Plans range from those offering only advice plus some office work to those which provide coverage of any and all legal problems with no exclusions. However, the majority of plans exclude personal injury or fee generating cases; other common exclusions are preparation of income tax returns and traffic court cases.

There are variations in the provisions of services in the United States. Plans which are “fully open”, offer a client the opportunity to choose any lawyer he wants for legal services covered under the schedule of the plan. Under “partly open” plans, a plan member may choose a lawyer from a specific geographic area or from a panel in which membership is open to any lawyer who subscribes to terms and conditions of the plan. In a “partly closed” plan, a small number of lawyers or law firms are available to the group member who has a choice within these narrow groupings. Finally, in “fully closed” plans, only full time staff lawyers are available to the group members.

Prepaid legal service plans have been divided into three principal categories:

- plans funded by union dues, as specified under collective bargaining agreements;
- plans sponsored by bar associations; and
- plans underwritten by insurance companies.

1. Pritchard, R. A., “Prepaid Legal Service Plans”, *Canadian Underwriter*, 1979.

In January 1978, the National Resource Centre for Consumers of Legal Services held a "Regulatory Conference on Prepaid Legal Services" in Denver, Colorado. The Denver Conference came to the consensus that:

- prepaid legal service plans ought to be subject to regulation;
- the ideal agency to regulate prepaid legal service plans was the State Commissioner of Insurance;
- in order to increase access to legal services, special regulations should be structured; and
- regulators should encourage experimentation and innovation, within the limits of their mandate, to provide consumer protection.

Still, the question as to whether or not prepaid legal service plans are insurance and accordingly should be governed by insurance legislation is unanswered in the United States. Many of the states have differing answers. However, twenty-two states have introduced special legislation since the fall of 1977 and nine states have passed enabling legislation.

The following comments highlight certain features of prepaid legal plans in the U.S. which may have a bearing on Canadian policy:

- Sponsors—Because of the decision that prepaid plans were not insurance, many insurance companies have been barred from participating in the prepaid field. State legislation varies; the Georgia legislation provides insurers with the greatest degree of access—plan sponsors can be any person, group or fraternal organization; whereas, in Oregon, legal service contractors can only be non-profit organizations.
- Financial Solidity—The main purpose of special legislation in the U.S. has been to avoid the large capital and reserve requirements of general insurance legislation. The requirements aimed at ensuring financial solvency are geared to the needs of the prepaid plans. For example, reserve funds are matched to the size of the operation, in Rhode Island a corporation must maintain a reserve fund of 10% of the projected costs of the first fiscal year and 10% of total expenses of subsequent years. Another example of the special legislation is the use of surety bonds and trust amounts, in Texas, any officer in charge of funds is required to carry a surety bond of \$25,000.
- Supervising Agencies—In the majority of states, the powers of regulation are vested in the Commissioner of Insurance. Massachusetts has left the supervision of prepaid plans to an eleven member panel in conjunction with the Commissioner of Insurance. In California, regulation is left to the State Bar of California.
- Preapproval and Rates—A standard feature of U.S. legislation is the preapproval of all policies and rates before marketing.
- Winding Up—Most states leave the question of liquidation of the sponsor corporations to general law.

Europe

European experience differs somewhat from that in the United States. In the United States, all prepaid legal service plans are sold on a group basis, except for Blue Cross which has plans to sell legal expense policies to both individuals and groups. In Europe, legal expense insurance is typically sold on an individual basis. In a study sponsored by the American Bar Foundation, it was found that European labour unions and similar employee groups have not been among the promoters of legal expense insurance, as has been the case in the United States.

“In a survey conducted in 1970 for the Conference of European Insurance Supervisory Offices, it was disclosed that 24 companies in five countries (Austria, Denmark, Germany, Spain, Switzerland) were writing legal expense insurance exclusively, and 207 multi-line companies in seven countries (Austria, Ireland, Netherlands, Portugal, Sweden, Spain, Switzerland) were transacting legal expense insurance in combination with other lines. Since 1970, the number of specialized legal expense insurance companies has increased considerably and programs have been introduced in several other countries (notably France and Britain).”¹

In Europe, insurers offer legal expense insurance with well defined coverage which is limited to legal controversies of a specified nature arising out of specified situations. Universal coverage policies extending to legal matters and services of all sorts rarely have been written in Europe and those that have been written have not been successful. European insurers extend coverage to expenses incurred in those legal matters that are beyond the control of the insured party. They do this by defining the situations and legal controversies that are covered and by making coverage of individual actions dependent on an evaluation of the merits of the insured's case. Routine legal services not related to any actual controversy and legal services in the area of preventive law usually are excluded. Typically European legal expense insurers operate the “open panel” plan with independent lawyers.

D. EXISTING CANADIAN LEGISLATION RELATED TO PREPAID LEGAL EXPENSE PLANS

In jurisdictions outside Canada, the primary aim of legislation regarding prepaid legal expense plans has been to protect the consumer. This includes defining and documenting the subscriber's rights as well as ensuring the fairness of terms and preventing unfair trade practices. All parties have appeared to recognize the need for protective legislation in this area.

In Canada, there is no specific legislation covering prepaid legal expense

1. Psennigstorf, “Legal expense insurance, the European experience in financing legal services,” American Bar Association, 1975, pgs. 23-24.

plans. In many provinces, these plans are considered to fall under insurance legislation. In their submission to the Committee, the Prepaid Legal Services Program of Canada discussed a survey of the Provinces of Canada conducted in February 1979 to determine if a plan would be treated as insurance if the sponsor contracted to:

“Pay for all the legal service costs incurred by the plan-holder (subscriber) up to a specified maximum excluding costs incurred in establishing or running a business or profession and not involving any indemnity for fines, judgment awards and third party legal costs.”

Sponsors listed were insurance companies, non-profit corporations, provincial law societies, labour unions, employees and a planholder’s trust.

The responses to the survey are summarized as follows:

- | | |
|-----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Alberta: | No definitive answer. |
| British Columbia: | Would be treated as insurance with the possible exception if the sponsor were the Provincial Law Society or if the costs of the service were entirely carried by the Government. |
| Canada: | Primarily insurance; operative criteria “if Party A undertakes to pay amounts to or on behalf of Party B on the happening of a defined contingency . . .” |
| Manitoba: | No response. |
| New Brunswick: | Be treated as insurance. |
| Newfoundland: | No response. |
| Nova Scotia: | Be treated as insurance. |
| Ontario: | Be treated as insurance. |
| Prince Edward Island: | Would be considered to be insurance if sponsor were an insurance company but not for other sponsors listed. |
| Quebec: | No definitive answer. |
| Saskatchewan: | Be treated as insurance unless legislative exemption obtained. |

At the present time, prepaid legal expense plans are recognized in Ontario under The Insurance Act. Some disagree with this treatment of prepaid legal plans. Although they recognize the necessity for regulations, they object to subjecting prepaid legal expense plans to the same requirements and restrictions applied to other insurance plans under The Insurance Act.

The major objectives of The Insurance Act are to ensure the solvency of insurance companies and to ensure that fairness exists between insurer and insured. Some aspects of The Insurance Act as its provisions relate to prepaid legal expense plans concern:

- Licensing—The Insurance Act requires a wide range of licences and licences are restricted to certain classes of business. For instance, some members of CAASI are not permitted to sell prepaid legal expense plans and consequently feel they are at a competitive disadvantage with the general insurance companies that have been licensed to sell both accident and sickness insurance plans and prepaid legal expense plans.
- Corporate Solvency—An insurance company must meet a minimum capital requirement to be licensed of \$1,000,000.
- Deposits—Insurers must deposit approved securities of at least \$25,000 with the Superintendent.
- Fairness—Insurance legislation has played an important role in protecting the insured. The regulations designed to ensure fairness are: preapproval of forms and policies; completeness of contracts; and, prohibition of certain advertising claims. The role of the Superintendent is largely to ensure adequate performance.

The Insurance Act was amended in March 1980 to include legal expense insurance. Legal expense insurance is defined as being:

“Insurance against the cost incurred by a person or persons for specified legal services rendered to such person or persons, including fees or other costs incurred relative to the provision of such services.”

The Prepaid Legal Service Program of Canada, although welcoming the recognition given to prepaid legal expense plans, feels that because of the solvency requirements for insurance companies and the absence of any general provisions for group insurance, the legislation will be inappropriate as a means of fostering the growth of plans in this country. They recommend the enactment of a special Prepaid Legal Services Act similar to The Prearranged Funeral Services Act and The Prepaid Hospital and Medical Services Act.

E. SUMMARY

Prepaid legal service plans are a recent innovation to paying for the cost of delivery of legal services in Canada. There are only a few organizations offering it as a product.

Labour unions might be an advocate of this type of service. However, the Canadian Labour Congress refuses to support the concept. Prepaid legal plans are not as pressing a priority as drug and dental plans and other forms of extended health services. The CLC is also cool to the idea because union leaders see it as a self-serving program for the legal profession.

Entrance into this market by organizations other than the traditional insurance companies has been slow due to the apparent onerous requirements of The Insurance Act.

“Proponents of a separate Prepaid Legal Services Act argue that the regulatory burdens appropriate for the large commercial insurers are neither necessary nor justified for all entities capable of providing legal expense plans. Obstacles in the present Act that prevent the growth of prepaid legal service plans amongst all of the small companies, groups and associations they are designed to assist, include (1) minimum capital requirements of \$1,000,000 in order to be licensed and (2) a requirement that the insurer deposit approved securities of at least \$25,000.

Several of the viable existing forms of legal service plans in Canada—individual credit unions, auto clubs and student unions—could not possibly hope to meet the requirements, yet these groups represent the kind of experimentation and initiative that must take place to provide greater access to legal services.”¹

Because of the limited number of insurance companies offering plans, a potential problem with respect to price competition arises. This apparent lack of competition leads to the question of whether or not regulations for legal service plans can be made with only the insurance companies in mind.

The absence of any general provisions for prepaid legal expense plans in legislation covering group insurance creates another significant obstacle to these plans. Group insurance legislation deals only with life and disability policies. It has been suggested that group legal plans would provide a much higher level of access to legal services than is currently available. The group market is no doubt essential to the development of prepaid legal service plans.

In order that Prepaid Legal Expense Plans may be regulated by appropriate legislation it is necessary to determine whether or not they are a type of insurance. As previously mentioned, in Ontario the plans currently fall under The Insurance Act. Europeans regard the plans as insurance while the situation in the U.S. is ambiguous.

Most definitions of insurance appear to include reference to the aspect of indemnification for loss arising from some form of casualty occurring. It has been argued that group legal service plans merely provide a service and use prepayment to finance the plan; thus not conforming to the traditional meaning of indemnity.

1. Wydrzynski, G. and Wilson L., “Prepaid Legal Services, Legal Representation for the Middle Class.”

PART VI

**PROBLEMS, GAPS AND ANOMALIES
IN THE PRESENT DISABILITY FINANCIAL
PROTECTION SYSTEM AND THE COMMITTEE'S
CONCLUSIONS AND RECOMMENDATIONS**

CHAPTER 21

An Overview

A. INTRODUCTION

There was no one who appeared before the Committee who did not comment in some way on the inadequacies of and problems with the disability financial protection system as operating in Ontario today.

The Superintendent of Insurance for the Province in his introductory remarks, commented that—

“Accident and sickness insurance combines the traditions of both life and non-life insurers plus its own special traditions to produce a wide variety of products to respond to consumer needs . . .

Problems in this sector usually extend from the major differences of operating traditions and practices of the various participants in the field. Extensive regulations and guidelines have been necessary to resolve problems arising from different approaches to each particular coverage.

The major problem at present is the co-ordination of private sector accident and sickness benefits with the wide range of government plans, particularly in the disability income field . . .”

CAASI, speaking for the insurance industry, indicated:

“One of the perhaps valid criticisms of the performance of the private accident and sickness industry is the relatively poor market penetration that is achieved among those sectors of the population which are either self-employed or are not members of large employee groups.”

CAASI, in its submission to the Government of Saskatchewan in February 1, 1978, a copy of which was appended to the brief submitted to the Committee during its September 1980 hearings, noted—

“The private insurance industry has on occasion been criticized for its performance in the provision of accident and sickness wage loss replacement plans. Critics charge first, that the industry is unduly selective in its underwriting and marketing processes. Second, that many individuals desirous of coverage are unable to obtain it at an affordable price. Third, critics point to the level of market penetration as evidence that the industry is not effectively meeting the needs of the public.”

Professor Reuben Hasson commented:

“In my view, disability insurance is a necessity of life which cannot be made universally available at reasonable cost by the private insurance industry.”

Professor Hasson then went on to explain his reasons for this observation—the inability of the private sector to market its product to individuals; its problems in establishing appropriate premiums that would protect insureds against inflation; and, the problems the private sector would face in co-ordinating safety and prevention programs and comprehensive rehabilitation programs.

Both Professor Belobaba and the Canadian Union of Public Employees (CUPE) made reference to a study conducted in Manitoba that indicated more than half of the injuries and deaths due to accidents result from non-work related, non-motor vehicle accidents and both of them made the point that “this is precisely in the area of non-work related short and long-term disability that coverage is weakest”.

There were a great number who appeared before the Committee who expressed the view that “insured services” covered by OHIP should be expanded.

Likewise, many observed both pro and con on the practice of some doctors in the Province to bill patients for certain charges in excess of the OHIP schedule of fees.

Both doctors and dentists also had complaints to make to the Committee through their respective associations.

There were those who appeared before the Committee who expressed their particular concerns with regard to the unco-ordinated, fragmented and inefficient safety and prevention and rehabilitation programs in the Province.

Critical comments could be extracted from most submissions made to the Committee. In addition, the Committee members themselves, from their own experience in dealing with their constituents and others, made such observations as:

- “gaps in accident and sickness fabric”
- “administratively costly”
- “some people not covered”
- “confusing”
- “probably ineffectively administered”
- “system not complete”
- “fault of system—people cut back after a few years”
- “problem—rehabilitation”
- “problem of duplication of payment of premiums and over-insurance”
- “public not aware of what they have and what they have not”
- “ignorance of coverage”
- “a lot of people don’t know what is available.”

B. WHAT IS WRONG WITH THE PRESENT SYSTEM?

As discussed earlier in this Report, it was clear to the Committee that it was impractical to dwell only on the role of the private sector in the disability financial protection system. It was necessary, therefore, for the Committee during its background analyses to cover the full spectrum of public disability financial protection programs as well as those offered by insurers and non-profit prepaid medical care organizations. In Part I of this Report, an overview of the present disability financial protection system in Ontario was developed and it is obvious that there are a great number of both public and private sector plans in place designed to respond, at least in part, to the perceived needs of the residents of Ontario. In Part II a more detailed review of the role of the insurance industry and non-profit prepaid medical care organizations in the accident and sickness protection system was outlined. Then in Part III, an overview was provided of the safety and prevention programs and the rehabilitation plans operating in Ontario today. A brief overview of some alternative disability financial protection plans suggested to the Committee during its hearings or operating or under consideration in other jurisdictions in Canada and throughout the world was provided in Part IV. The information contained in these Parts of the Report, together with information in submissions made to the Committee and research and analyses conducted by others, has enabled the Committee to develop an appreciation of "what is wrong with the present system?" In order to suggest appropriate solutions, it is necessary to appreciate the problem.

Probably the most important *conclusion* reached by the Committee was agreement in principle with the need for a universal, comprehensive, integrated system of disability financial protection for residents of Ontario. While the Committee realizes that this is not possible immediately, it is nevertheless loath to patch the present system and indeed does not believe that patching can be done well. Nevertheless, the Committee is prepared to deal with the system as presently in force in Ontario and make suggestions aimed to smooth out some of the problems and gaps and, as a minimum, improve the system as it presently exists. The Committee, however, believes that the ultimate aim must be one comprehensive plan for all residents of Ontario.

Further reference to the components of a comprehensive system are discussed more fully in Chapter 24; included also is a "shopping list" of suggested features of such a system.

The problems, gaps and anomalies in the present system of disability financial protection in Ontario are reviewed in the following portion of this Part under the following headings:

- financial protection against the costs of medical care;
- financial protection against the costs of dental care;
- considerations regarding a comprehensive disability income protection system;

- income protection during periods of disability—improving the present system;
- rehabilitation and duration and termination of benefits;
- safety and prevention; and
- confidentiality of health information.

CHAPTER 22

Financial Protection Against the Costs of Medical Care

A. INTRODUCTION

The Committee is *unanimous in its view* that in matters relating to medical care, the residents of Ontario expect to be free from substantially all the costs of medical care at the time of an accident or sickness and during periods of recovery and rehabilitation.

By means of the OHIP plans, basic medical care coverage is universally available to residents of Ontario. The details of the medical care costs covered by OHIP were outlined in Chapter 2. The medical care costs that are *not* covered by OHIP were also set out in that chapter and include:

- any hospital charges for private or semi-private accommodation;
- hospital visits solely for the administration of drugs;
- charges for dental care except as specified;
- eyeglasses, artificial limbs, crutches, special braces and other such appliances;
- private-duty nursing fees;
- drugs taken home from the hospital;
- transportation charges other than approved ambulance service;
- medical examinations or certificates required for applications for employment or the continuance of employment, life insurance, or admission to camps or recreational activities;
- cosmetic surgery;
- acupuncture;
- any health service other than those provided by approved hospitals or practitioners as specified.

Various extended health care plans available through non-profit prepaid medical care organizations and insurance companies provide coverage to groups and individuals to cover certain of the medical care costs not covered in the basic OHIP plan. These medical care costs include:

- differentials for the extra cost of semi-private and private accommodation at hospital;
- nursing home care;
- services through a plan medical centre;
- prescription drugs;
- dental care;
- hearing care and hearing aids;
- vision care and eyeglasses;
- special duty nursing;
- local ambulance services;

- appliances;
- wheelchair rental;
- health care outside Ontario and outside Canada;
- health care for visitors to Canada.

While it is difficult to define precisely “medical care costs” it would seem apparent that some costs that would likely be included by most in such a definition are not covered either under the basic OHIP plan or under any of the extended health care plans presently available in Ontario. Some of the items for which coverage may not presently be obtained include:

- the costs of hospital visits solely for the administration of drugs;
- many transportation charges other than ambulance charges;
- medical examinations required for employment, life insurance, admission to camps or recreation activities;
- cosmetic surgery except as defined by OHIP as being “Cosmetic Surgery refers to services for the purpose of beautifying the body or improving the physical appearance where there is no health related effect. Health related effects include physical health and mental or emotional health. The latter would be determined by the physician or psychiatrist treating the patient. Cosmetic surgery includes procedures such as face-lifts, and changing the shape of a nose.”
- acupuncture;
- health services other than provided by approved hospitals or practitioners as specified.

The thrust of the Committee’s conclusions and recommendations as they relate to medical care coverage for the residents of Ontario is that the services included should be subject to constant scrutiny first by OHIP and then by those offering extended health care plans, with the aim of producing the broadest practicable definition of medical care coverage. In the Committee’s view, both OHIP and the private sector should be encouraged to examine services they do not cover with a view to needs and affordability. Based on these reviews, the goal should be to expand “insured services” in the case of OHIP and extend medical care coverages to include services presently not covered under extended health care plans offered by the private sector.

The Committee believes that these matters are of sufficient importance that it makes the following specific recommendations:

1. The Committee recommends that OHIP carry out careful analyses of exclusions from “insured services” and consider, for example, among other matters;
 - (a) transportation costs of those in Northern Ontario requiring medical care and treatment;

The Committee recommends that this particular subject be given high priority by OHIP since it is generally recognized that residents of Northern Ontario do not get as good service as other residents of

the Province because of their isolation and the fact that services are not generally available. In this regard, the Committee is cognisant of the concern expressed by some that, if payment of transportation costs is readily available to residents of the north, there will be less incentive than ever for doctors to move to the north and possibly there will also be less emphasis on developing adequate medical care facilities in the area.

- (b) significant transportation costs, other than by ambulance, of those requiring medical care and treatment that is only available at specialized hospitals and treatment centres;
 - (c) certain prescription drugs such as serums, injectibles and insulin;
 - (d) artificial limbs;
 - (e) braces;
 - (f) boots, splints and trusses;
 - (g) wheelchairs, crutches, canes and walkers;
 - (h) other prosthetic devices;
 - (i) respirators;
 - (j) hearing aids for children;
 - (k) eyeglasses for children;
 - (l) corrective eye surgery for children;
 - (m) cosmetic surgery for children;
 - (n) acupuncture;
2. It is the recommendation that OHIP be required to report to the Minister of Health and to the Assembly on the results of their analyses as they relate to the needs for each of these services and the cost implication of adding them to "insured services" provided by OHIP.
 3. The Committee also recommends that analyses similar to those set out in its first recommendation be undertaken on a regular basis with the intent of ensuring that there is a constant review and regular reporting to the Minister of Health on the possible extension of insured services by OHIP. The report on this matter should be included in the regular report of the Ministry of Health produced each year.
 4. The Committee recommends that OHIP adopt an attitude of being more liberal in considering individual cases and applying greater discretion in assessing each case with the general aim of extending as far as practicable the services for which it is prepared to reimburse residents for the medical care costs they incur. The Committee encourages OHIP to adopt a more generous attitude in its interpretation of reimbursable transportation costs and costs of cosmetic surgery.

B. MEDICAL CARE COVERAGE UNDER GOVERNMENT PLANS

The federal and all provincial governments have long recognized the importance to the citizens of Canada of access to medical care and financial

protection against the costs of that care. While the Committee recognizes that there may be alternatives to the present medicare plan in Canada and these were reviewed briefly by the Committee during its study, the Committee *concluded* that the basic plan in Ontario—OHIP—is best among those presently available.

OHIP—A Universal Plan

The concept underlying OHIP is that it should be a universal plan. However, it is not mandatory in Ontario and, as a consequence, there are some, either by choice or ignorance, who do not participate in the plan. The Committee discussed the advisability and feasibility of making the plan compulsory but decided against such a recommendation. The Committee believes, however, that all should be encouraged to participate in OHIP. In this regard the Committee has two recommendations that it offers for consideration.

5. The Committee recommends that a question be included on the Ontario portion of personal income tax returns inquiring “Are you covered by OHIP, either individually or in a group plan?”
6. It is also recommended that OHIP conduct an annual campaign at a specified time each year, encouraging those who are not participating in OHIP to do so.

The Committee was somewhat dismayed that it was unable to obtain information concerning the number of residents of Ontario, either covered by OHIP or alternatively not covered by the plan.

Paying For OHIP

The appropriate method of paying for the Ontario portion of the costs of OHIP, whether by premium or otherwise, while given some consideration by the Committee, was not dealt with in depth by it. The Committee felt that this matter was beyond the scope of its terms of reference. However, the Committee would like to voice its *approval* of the following comment made by the Treasurer in his 1981 budget—

“Mr. Speaker, some Members think that premiums are not an appropriate health financing vehicle. Let me say that I intend to explore in depth other financing options, such as a payroll tax. But I wish to emphasize there are significant implications which could still justify continuing a premium financing. I invite and welcome comment on this matter during the coming year.”

Anomalies in the Medical Care Provisions of Various Government Plans

In Part I and again in the Introduction to this Chapter, the medical care coverages included as insured services by OHIP were discussed. Also in Part

I, the other government plans were reviewed. The Committee observed that there were anomalies in medical care coverage provided under a number of these other government plans when compared to OHIP.

In the case of workers covered by workers' compensation, and injured on the job, they will have all medical care costs paid, not only those covered by OHIP but also the extra costs billed by doctors over the OHIP schedule of fees to the limit of the WCB schedule of fees. In addition, workers will be covered for all extended health care costs that may be involved in their care and rehabilitation. Further, it is worthy of note that the Workmen's Compensation Board will frequently pay travel costs, if approved in advance, and will also pay maintenance costs, clothing allowances and attendant's allowances to injured workers who need continuing treatment and rehabilitation.

A matter of particular interest to the Committee was that the Workmen's Compensation Board has negotiated a schedule of fees it will pay doctors that is higher than the OHIP schedule of fees although both are lower than the Ontario Medical Association schedule of fees issued by the OMA for the guidance of doctors. Doctors may not make any excess billing to injured workers over and above the established WCB schedule of fees.

Residents injured in automobile accidents will also be covered for all of their medical care and rehabilitation costs without restriction. Third-party liability and accident benefit automobile insurance is compulsory in Ontario. Schedule E of The Insurance Act sets out the "mandatory medical rehabilitation benefits, and accident benefits in motor vehicle liability policies." Portions of this Schedule are reproduced in Appendix H to this Report including the following particular section as it relates to medical rehabilitation and funeral expenses—

"Accident Benefits Section

The Insurer agrees to pay to or with respect to each insured person as defined in this section who sustains bodily injury or death by an accident arising out of the use or operation of an automobile.

Subsection 1—Medical Rehabilitation and Funeral Expenses

1. All reasonable expenses incurred within four years from the date of the accident as a result of such injury for necessary medical, surgical, dental, chiropractic, hospital, professional nursing and ambulance service and for any other service within the meaning of insured services under The Health Insurance Act and for such other services and supplies which are, in the opinion of the physician of the insured person's choice and that of the Insurer's medical advisor, essential for the treatment, occupational retraining, or rehabilitation of said person, to the limit of \$25,000 per person.

2. Funeral expenses incurred up to the amount of \$1,000 in respect to the death of any one person.

The Insurer shall not be liable under this Subsection for those portions of such expenses payable or recoverable under any medical, surgical, dental, or hospitalization plan or law or, except for similar insurance provided under another automobile insurance contract, under any other insurance contract or certificate issued to or for the benefit of, any insured person.”

Somewhat similar to the two examples concerning injured workers and those injured in automobile accidents, persons qualifying for benefits under the criminal injuries legislation of the Province are also covered for actual medical care costs that cannot be recovered either through OHIP or their personal insurance. In this case, however, the Board responsible will not pay the excess billings by “opted-out” doctors.

In reviewing the treatment afforded those injured at work, in automobile accidents or by criminal acts, the Committee could not visualize taking away the benefits provided in these cases and limiting medical care costs that would be reimbursed to injured parties to the amount payable under OHIP. Rather, the Committee believes that there should be a common level of benefits for all victims of accident and sickness regardless of the cause of their need for medical care. The Committee is of the opinion that the place to start is to improve the OHIP benefits.

7. The Committee recommends that improvement be made in the insured services covered by OHIP with the ultimate aim of establishing a common level of benefits for all residents of Ontario requiring medical care.

Workmen’s Compensation Board Medical Aid Claims

The Workmen’s Compensation Board, in addition to providing for income protection and rehabilitation for injured workers, provides for their medical care. In order to manage this portion of the Board’s operations it has set up an organization similar in many ways to the organization at OHIP which controls the records, costs and other data concerning medical care services. Professor Weiler observed on this duplication of services and suggested that there would be considerable cost savings to the WCB if OHIP handled all medical aid claims and provided the necessary information to WCB to let the WCB control its operations and to form the basis of subrogation payments from the WCB to OHIP. To quote Professor Weiler⁽¹⁾—

“The Workers’ Compensation Board now processes over 250,000

⁽¹⁾ Paul C. Weiler—Rehspaing Workers’ Compensation for Ontario—Pages 104 to 106

claims a year in which the employee has not lost any time from work and for which the Board need replace no income. Yet the Board must establish a file for each such case, decide whether the injury was occupational or not, and, if it was, pay the hospital or doctor bills. This procedure made sense 60 years ago, when this was the only method of insuring that the worker's medical costs were covered. Now we have a comprehensive program for public health care insurance. The Ontario Health Insurance Plan (OHIP) has a large organization which specializes in paying all doctor bills, except those for work-related injury and disease. Why shouldn't OHIP add this comparatively small number of cases to its system, relieving the Workers' Compensation Board of the responsibility for processing fully 60% of the cases the Board handles every year?

One question which might be asked relates to financing. The costs of health insurance will necessarily go up if the treatment of occupational injuries is to be covered by this system instead of by workers' compensation. But OHIP is paid for out of individual premiums and general tax revenues, only part of which come from business. The premise of workers' compensation is that employers should pick up the entire tab for the economic costs of industrial accidents, including treatment costs, in order to optimize accident prevention through general market deterrents. The simple answer to this objection is that OHIP would bill the Workers' Compensation Board every year for the expense of insuring occupational injuries (and for this purpose a general formula for calculating these costs would be sufficient). The Workers' Compensation Board could then pass this cost along in assessment rates in accordance with the principles of the compensation system.

Alberta is proposing to have its health care plan assume responsibility for medical treatment of occupational injuries (without any shift of the costs back to the Workers' Compensation Board). In my discussion with the Ontario Board about the prospects of doing this here, certain problems loomed on the horizon. For example, OHIP does not insure all the costs of treatment which are now covered by workers' compensation (necessary drugs, for example). These would still require that claims be made to the Board by injured workers. Many injuries which start out as pure medical aid claims eventually recur in more serious lost-time cases. While the time span between these two events is normally quite short, occasionally it is not, and the Board would face some difficulties in retrieving the information about the earlier accident and treatment from the parties (since it is unlikely to be able to get this from OHIP).

These are minor difficulties which pale into insignificance beside the major problem. A key to adjudication of lost-time claims by the Board is the report from the worker's doctor covering the fact of a disabling injury, its nature, its origin, and the worker's state of recovery. These

reports are the major source of delay in the system, especially in routine cases. Right now doctors have a personal incentive to cooperate with the Board in expediting the lost-time claim. The sooner they get their material in, the sooner the Board will be able to pay their bills. Suppose that OHIP were to take over the responsibility for paying the doctor's bill. That source of self-interest would be gone. Doctors typically do not like taking time out from practicing medicine to make out reports to government agencies. Although most would cooperate for the benefit of their patients, they would probably take their time in doing so. This change in the program, intended to alleviate delay in the system, might well become a source of even more holdups. True, the Workers' Compensation Board could and would pay a fee for these reports. But my discussions with medical authorities in this province have convinced me that the reporting fee would have to be hefty in order to be an effective inducement (considerably more in the routine case than the eleven percent differential which the Workers' Compensation Board now pays doctors over and above the OHIP scale). At the same time, the Board would lose the leverage it now has in monitoring treatment services and costs (which now saves a good deal of the money needed to pay for the current higher fee schedule).

Still, one has to weigh these problems against the gains the Board might achieve by being relieved of the administration of medical aid claims. In and of itself, these gains might not seem substantial. While significant in number, medical aid claims are relatively simple and require only a small staff to process them. On the other hand, I suspect that the Board would reap subtler but substantial advantages in the long run from having its mail room, its computer, its accounting department, and so on relieved of this massive volume of case files every year. Certainly the results in Alberta must be observed closely. At the minimum, consideration should be given to transferring to OHIP the responsibility for medical bills and industrial injuries which do not involve any loss of working time by the employee (and thus where there is no problem of expediting physicians' reports to Board adjudicators).''

The Committee decided it cannot support Professor Weiler regarding his suggestion that OHIP handle all medical aid claims and provide the necessary information to WCB. As indicated from the foregoing quotation, Professor Weiler recognized many of the problems with his suggestion. In addition, the Committee is of the opinion that the Board must continue to have its own records of work-related injuries and industrial disease.

8. The Committee recommends, contrary to the suggestion of Professor Weiler contained in his report "Reshaping Workers' Compensation for Ontario," that the Workmen's Compensation Board continue to have its own records of work-related injuries and industrial disease and not pass the responsibility for maintaining any relevant records to OHIP.

“Opted-Out” Doctors

The subject of excess billing by doctors over the OHIP schedule of fees for services, commonly referred to as “opting-out” by the doctors, was a matter of great concern to and the subject of considerable discussion by the Committee.

By way of background, the Committee had available to it detailed information tabled in the Assembly on May 15, 1980 by the Minister of Health and referring to statistics as at April 1980, portions of which are summarized below.

“The most up-to-date opt-out position for the province as a whole as of April 1980 is:

	#	%
GPs	549	8.7
Specialists	1,522	25.6
Total	2,071	16.9

This provincial aggregation includes future option notifications by physicians. Tabulation “A” attached does provide this provincial aggregate broken down on a county basis. Tabulation “B” provides the number and percentage of opt-out specialists in the province.”

TABULATION “A”
NUMBER AND PERCENTAGE OF OPTED-OUT PHYSICIANS
BY COUNTY—APRIL, 1980

County	# Physicians			% Opted-Out		
	GP	SP	Total	GP	SP	Total
Algoma	1	1	2	1.3	1.8	1.5
Brant	2	1	3	3.1	1.7	2.4
Bruce	-	-	-	-	-	-
Cochrane	2	1	3	3.4	5.0	3.8
Dufferin	1	-	1	4.5	-	4.0
Durham	-	-	-	-	-	-
Elgin	-	1	1	-	4.3	1.6
Essex	13	11	24	7.3	6.8	7.1
Frontenac	4	3	7	3.9	1.8	2.6
Grey	3	7	10	5.5	21.2	11.4
Haldimand/Norfolk	-	3	3	-	42.9	5.5
Haliburton	-	-	-	-	-	-
Halton	31	42	73	17.9	32.8	24.3
Hamilton/Wentworth	16	37	53	5.3	10.1	7.9
Hastings	1	-	1	1.3	-	0.8
Huron	1	1	2	2.6	16.7	4.4
Kenora	-	-	-	-	-	-
Kent	-	-	-	-	-	-
Lambton	10	17	27	14.9	29.3	21.6
Lanark	-	-	-	-	-	-
Leeds/Grenville	4	3	7	7.0	10.0	8.0
Lennox/Addington	-	-	-	-	-	-
Middlesex	28	93	121	9.6	25.8	18.6

Muskoka	-	1	1	-	11.1	2.5
Niagara	17	48	65	7.3	27.9	16.0
Nipissing	4	7	11	7.5	22.6	13.1
Northumberland	-	1	1	-	10.0	2.0
Ottawa/Carleton	45	128	173	12.6	20.3	17.5
Oxford	7	1	8	11.7	5.0	10.0
Parry Sound	-	-	-	-	-	-
Peel	23	51	74	9.2	41.1	19.8
Perth	5	8	13	11.1	42.1	20.3
Peterborough	-	32	32	-	37.2	19.2
Prescott/Russell	-	-	-	-	-	-
Prince Edward	1	-	1	6.3	-	5.0
Rainy River	-	-	-	-	-	-
Renfrew	-	1	1	-	4.8	1.4
Simcoe	33	23	56	22.4	34.8	26.3
Stormont/Dundas/Glengarry	-	2	2	-	5.0	1.9
Sudbury	7	18	25	7.1	21.2	13.7
Thunder Bay	1	6	7	1.2	7.3	4.3
Timiskaming	-	-	-	-	-	-
Victoria	-	1	1	-	9.1	2.4
Waterloo	36	46	82	19.8	30.7	24.7
Wellington	19	31	50	25.0	41.9	33.3
York R.M.	37	48	85	24.0	57.8	35.9
Province ⁽¹⁾	549	1,522	2,071	8.7	25.6	16.9

(1) The county data is adjusted to eliminate inconsistencies arising from such features as physician relocations. These features are taken into account at the provincial level and consequently simple addition of county numbers in any one month may not necessarily coincide with the provincial totals.

TABULATION "B"
NUMBER AND PERCENTAGE OF OPTED-OUT
SPECIALISTS—APRIL 1980

ONTARIO

Specialty	Opt-Out	Percentage
General Practice	549	8.7
Anaesthesia	321	62.9
Dermatology	13	9.8
General Surgery	147	22.0
Neurosurgery	8	15.1
Orthopaedic Surgery	105	41.8
Plastic Surgery	44	48.4
Thorac & Cardio. Surgery	2	5.9
Internal Medicine	77	7.4
Neurology	7	6.8
Psychiatry	275	35.0
Obstetrics & Gynaec.	227	43.9
Ophthalmology	132	45.2
Otolaryngology	54	26.9
Paediatrics	24	5.3
Pathology	2	2.0
Microbiology	1	25.0
Physical Medicine	1	2.0
Diagnostic Radiology	11	2.8
Urology	67	42.9
Gastroenterology	3	33.3
Cardiology	1	3.1
	<u>2,071</u>	<u>16.9</u>

It is the understanding of the Committee that the situation in mid 1981 does not differ significantly from the situation in April of 1980.

As the Committee reviewed these statistics on the doctors who have opted-out of OHIP it was struck with the high portion of specialists who have done so and in particular those specialists who make extensive use of, and likely would be unable to carry on their practices without, facilities provided for them by the taxpayers of Ontario.

The problem of doctors opting-out of Medicare in Canada is not unique to the Province of Ontario. While exact statistics are not available province by province, doctors dissatisfied with the remuneration for their services are extra billing or opting-out of provincial medical care plans in most provinces. Estimates of the proportion of opted-out doctors range from a low of less than 0.1% in Quebec and British Columbia to about 6% in Manitoba and nearly 17% in Ontario. There are a variety of ways in which doctors are paid in each province—

- In Quebec, a doctor may choose to be either totally in or totally out of the provincial health insurance plan. Patients of doctors who are out of the plan must pay the entire bill and cannot recover any part of it from the plan except in the case where the patient had to use the doctor in an emergency. In this latter circumstance the doctor would collect only the schedule of fees stipulated in the plan for the service provided. The requirement that the doctor either participate or not participate in the provincial health plan in Quebec ensures that almost all doctors participate and do not make excess billings. The Committee understands that there are only six opted-out doctors in Quebec.
- In British Columbia, as a result of recently completed negotiations between the provincial health insurance plan and the association representing doctors in the Province, the situation is now similar to that in Quebec regarding doctors being either totally in or totally out of the plan. However, in British Columbia, patients of an opted-out doctor may recover from the plan according to the negotiated schedule of fees. As of August 1981 there is only one opted-out doctor in British Columbia.
- In Nova Scotia, doctors may make billings over and above the schedule of fees established under the plan without opting-out and are able to collect the negotiated plan fee from the provincial plan and the extra amount from the patient.
- In Alberta, doctors may bill the plan, their patients or both without opting-out of the provincial scheme. The Committee understands that approximately 35% of Alberta doctors extra bill their patients.
- In Prince Edward Island, New Brunswick and Saskatchewan doctors are permitted to bill in excess of the schedules of fees negotiated with

the plan on particular cases without opting-out in general. Patients in such circumstances of extra billing are reimbursed by the plan according to the negotiated schedule of fees.

- In Manitoba and Newfoundland doctors who wish to make excess billings to their patients over and above the schedule of fees negotiated with the plan must opt-out of the plan and collect all of their fees from their patients. The patients are reimbursed from the plan to the extent of the schedule of fees for the service provided by the doctor as stipulated in the plan.
- In Ontario doctors are permitted to be totally in the plan, totally out of the plan or partially in and partially out of the plan. Doctors who are totally in the plan are reimbursed by OHIP according to the OHIP negotiated schedule of fees. Patients of doctors who have opted-out of OHIP are billed directly by their doctors and may recover from OHIP according to the OHIP negotiated schedule of fees for the services provided. Doctors may decide to be either “opted-in” or “opted-out” for individual patients. If the doctor decides, for whatever reason, that he will not excess bill a particular patient then he may, for that patient, act as if he is an opted-in doctor and be reimbursed directly by OHIP for his services to that patient. The doctor may decide to excess bill others of his patients, in which case he looks to the patients to pay the total amount of his bill with the patients able to recover from OHIP a portion of these fees, according to the OHIP schedule of fees.

The Committee could not help but be impressed with the success that the Province of Quebec and British Columbia have had in minimizing the number of opted-out doctors, although the Committee has not attempted to determine the ramifications of these systems and whether there are serious underlying problems and frictions between the doctors and the provincial governments.

The Committee would have no difficulty in developing a rationale prohibiting the opting-out of doctors. The Committee has already expressed its view that it favours in principle a universal comprehensive disability financial protection system for residents of Ontario. To permit opting-out of doctors is entirely incompatible with the concept of such a system. However, at the present time, the Committee does not believe that the best solution lies in forcing the doctors to remain in OHIP.

9. The Committee recommends the application of a better process of establishing the negotiated OHIP schedule of fees for doctors' services. These rates must be seen to be fair both to the doctors and to the residents of Ontario through their negotiator OHIP. It may be that appropriate arbitration procedures is where the answer lies.

The question of the containment of medical care costs and opting-out doctors is not a new problem in Ontario. In 1978, a Select Committee on

Health-Care Financing and Costs under the chairmanship of Bruce McCaffrey, M.P.P. prepared a report dealing with three specific issues. The terms of reference of that Committee contained three specific areas of consideration:

1. "To review Ontario's health-care costs, health-care financing methods, and services provided for that expenditure; and then to compare that profile with those of other provinces and countries as the committee may deem appropriate for purposes of providing a valid basis for comparison.
2. To review alternative methods of financing the health-care system and the impact of those alternatives on the fiscal and economic affairs of the Province; and to make recommendations thereon.
3. To review existing reports which relate to methods and means of containing or reducing health-care costs, and to report its findings to the Legislature."

In its report the Committee noted:

"A good deal of the Committee's time was devoted to the consideration of user charges in various forms. . . . The issue is . . . complicated by the many guises under which user charges may appear in the system; in addition to direct charges made to patients at the time of service, user charges can occur in the form of co-insurance or deductible payments in connection with insured services, treatment of health services received as taxable income, supplementary charges by physicians under a balanced-billing system, charges by opted-out physicians in excess of the OHIP benefit, and so forth. One cannot, then, sensibly address the topic of user charges without considering the question of physician remuneration . . ."

In response to questions concerning user charges as deterrent fees and the use of health care services for borderline necessity and the abuse of the health care system, the Committee reported—

"Ontario physicians indicate that only about 10% of services provided were not medically necessary *in the opinion of the physician*. Interestingly the same survey indicated that the high percentage of patients, about 12%, waited too long before seeking medical attention."

Further

"the Committee notes the Saskatchewan experience with deterrent fees in the period 1968-1971, when there was only a marginal reduction in overall utilization but a significant decrease in the utilization rates of the poor. Interestingly, the utilization rates of richer patients actually *rose* during the period of "deterrent" fees. Such a distortion in the pattern of care would be entirely unacceptable in the Committee's view.

The problem with deterrent fees, then, is that in general they cannot be expected to deter very much, but in particular they may deter altogether the wrong people.

This brings us to a consideration of the general problem of access to health services. In a context where there are differential charges to different kinds of patients, the question of equal access to the health system comes to the fore. This could occur under a system of "balanced-billings" where physicians bill both OHIP and patients, or in the case of opted-out physicians. Indeed, proponents of direct billing have suggested to the Committee that special treatment be afforded to the "medically indigent," in order to countervail the *undesired* deterrent effects. Such a policy, however, goes entirely against the grain of our public health insurance program which is committed to ensure equal access to the health care system without regard to the ability to pay."

In dealing with the subject of the remuneration of doctors as it related to OHIP the Committee observed further:

"It appears that the principal motivation behind the recent increase in opting-out is generalized dissatisfaction in the medical profession with the level of fees. It has been suggested to us that these do not now constitute "reasonable compensation", and that, as a consequence, physicians either resort to a "revolving-door" kind of medical practice in order to maintain their incomes, or they opt-out and raise fees unilaterally. The former effect represents a dilution in the quality of care provided to patients; the latter consequence results in the "privatization" of the costs of medical care and the potential for differential access.

... The dilemma confronting physicians of maintaining incomes either by diluting the level of service or by opting-out and charging higher fees threatens to generate a serious challenge to the exemplary functioning of our medical care system."

The Committee then went on to conclude—

"that a policy of "cost containment" in the medical sector, which relies mainly on restricting the level of fees is unsound; it leads either to revolving-door practices with the concomitant dilution in the level of care, or to opting-out with the resulting transfer of costs (not containment) from the public to the private purse. The Committee urges the government to reconsider its policy with respect to the O.H.I.P. Schedule of Benefits. In particular, it commends to the attention of the government a system of negotiating fees and utilization rates concurrently, so as better to promote the two objectives of quality care and cost containment without economically penalizing medical practitioners. If, for example, the government were to

negotiate a multi-year agreement with the profession, incorporating a substantial increase in fees in exchange for a commitment to hold constant the level of utilization (decelerate the “revolving-doors”), both these objectives could be achieved. To ensure cost containment, the fee increases the subsequent years could be made contingent on the utilization performance in the first year. Such a scheme has now been successfully (and amicably) negotiated in Quebec, and seems to be working very well on the basis of early anecdotal reports. It appears that such a scheme could address the legitimate concerns of the medical profession over the level of fees, as well as the need for responsible cost-control by the government. If so, the vexing trends in medical practice and in opting-out might be reversed, or at least mitigated.

There remains one final issue in connection with this general topic which needs to be addressed. Throughout this discussion, we have considered user charges in the form of deterrent fees or supplementary charges by physicians only in the context of cost containment. As we noted above, however, they can alternatively be considered in the context of financing the system, that is, as a source of additional revenue. If indeed user charges are not effective deterrents overall, and utilization declines less than fees rise, then additional revenue will be generated. The Committee generally rejects this device as an appropriate way of raising revenues.”

The underlying concern of our present Committee regarding excess billings by certain doctors is that it may lead to the collapse of the present Medicare system in Ontario because it will deny reasonable access to insured services by insured persons. The Committee agrees with the observations of the 1978 Select Committee on Health-Care Financing and Costs regarding user fees.

10. The Committee recommends that user fees not be introduced into the health-care system of the Province and that the arguments for the use of such fees as a means of controlling the utilization of services, of cost containment and of providing “reasonable compensation” to medical practitioners be rejected.

Under the present federal/provincial cost sharing agreement for Medicare the provinces receive a straight 50% of the national average per capita cost. One of the criteria for eligibility for the federal contribution to shared costs for insured services under the Canada Medical Care Act reads as follows:

“To be eligible for the federal contribution to shared costs for insured services under this Act, a provincial plan must meet the following criteria:

- (b) the plan provides for and its administered and operated so as to

provide for the furnishing of insured services upon uniform terms and conditions to all insurable residents of the province, by the payment of amounts in respect of the cost of insured services in accordance with a tariff of authorized payments established pursuant to the provincial law or in accordance with any other system of payment authorized by the provincial law, on a basis that provides for reasonable compensation for insured services rendered by medical practitioners and that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons;"

The particularly important phrases in this section concern—the principle of providing insurance services on “uniform terms and conditions to all insurable residents of the province”; the principle of providing for “reasonable compensation for insured services rendered by medical practitioners”; and, the principle of “reasonable access to insured services by insured persons”.

The federal government and in particular the Health Minister, Monique Begin, have expressed concern regarding “a serious decline in the quality of health care” as a result of allowing doctors to bill more than they get from Medicare. The present cost-sharing agreement between the federal government and the provinces is due to expire on March 31, 1982 and there have been suggestions by Madame Begin and others that a reevaluation may be necessary if the basic principles underlying the cost-sharing plan are in jeopardy.

While the Committee is not in a position to make specific recommendations regarding an appropriate solution to the problem of excess billing by certain doctors in Ontario.

11. The Committee must express the urgency of its concern and the consensus that it reached that the present Medicare system in Ontario not be allowed to collapse. The Committee believes that the solution to the current problem of excess billing by certain medical practitioners lies in give on both the side of the government through OHIP and the medical practitioners to arrive at a schedule of fees acceptable to both that will ensure that Medicare continues for the benefit of the residents of Ontario. The Committee recommends that steps be taken immediately by both sides to ensure resolution of their differences.

Insurance to Cover Excess Billings by Opted-Out Doctors

Some have suggested that extended health care plans offered by insurers and non-profit prepaid medical care organizations be permitted to cover excess billings for OHIP insured services.

12. The Committee recommends that insurers and the non-profit prepaid medical care organizations continue to be prohibited to sell coverage for excess billings for OHIP insured services. To do otherwise would lead to two separate systems of medical care in the Province and destroy the concept of "furnishing of insured services upon uniform terms and conditions to all insured residents of the province" in which the Committee firmly believes.

Notification of the Patient of Excess Billing by Opted-Out Doctors

Ontario physicians must comply with Regulations under The Health Discipline Act, 1974. Its reference to "professional misconduct" includes the following:

- "a) requiring payment for an insured service under OHIP, as a condition to be met before completing a claim card;
- b) requiring payment for an insured service under OHIP, before providing an itemized account of the service;
- c) charging a fee that is in excess of the fee listed in the current Ontario Medical Association fee schedule, without prior notification to the patient as to the excess amount of the fee."

It is interesting to note that these regulations do not prohibit payment being demanded by the physician from a patient before the service is performed.

While the Committee has indicated it hopes that the discrepancy between the OMA schedule of fees and the negotiated OHIP schedule of fees will be resolved, nevertheless, as the foregoing regulations presently read in item c) a physician need only inform a patient that a fee will be in excess of the amount listed in the current OMA schedule, which means little to the patient who is concerned only with the amount OHIP will cover.

13. The Committee recommends that the regulations under The Health Discipline Act, 1974 in a reference to "professional misconduct" be amended to include "charging a fee that is in excess of the fee listed in the current OHIP fee schedule, without prior notification to the patient as to the excess amount of the fee."

Extended Health Care Coverage for Christian Scientists

The Christian Science Committee on Publications for Ontario in a submission to the Committee requested clarification of the Ontario Government's policy regarding Christian Science and sickness and accident insurance. The submission was prepared by Mr. Don Fulton who represents the

Christian Scientists on matters affecting the religious freedom and practices of Christian Scientists.

In 1975, Mr. Fulton undertook to contact most of the major insurance companies in Ontario to enquire as to each company's policy on the recognition of Christian Science care and treatment as an alternative to medical care. Of all the insurers queried, none offered policies covering sickness and accident insurance to accommodate Christian Science care and treatment on an individual basis. A number of companies were willing to accept a Christian Science rider to group insurance policies if the policyholder seeking coverage requested it.

The Insurance Bureau of Canada in a general bulletin concerning Christian Science treatment and automobile insurance indicated:

“the insurer agrees to pay all reasonable expenses for necessary medical, surgical . . . service and, in addition, for such other services and supplies which are, in the opinion of the insured person's attending physician and that of the insurer's medical advisor, essential for the treatment or rehabilitation of said person.”

The bulletin then went on to say

“that payments for the service of Christian Science practitioners would be payable when the insured's attending physician and the insurer's own medical advisor have agreed that such treatment is essential for the treatment or rehabilitation of that person.”

The IBC then stated that

“it could not find justification in law to consider a Christian Science practitioner as holding the status of a physician.”

Finally, the bulletin pointed out that

“an appropriate guideline would be to establish whether or not a provincial medical plan recognizes qualified treatment by such practitioners as the equivalent of medical services, and if so to accept a claim for payment.”

It would seem from the foregoing that the IBC is attempting to hide behind OHIP as justifying its reason for not making readily available policies covering sickness and accident insurance to accommodate Christian Science care and treatment. The IBC is doing this by suggesting that an appropriate guideline would be whether or not a provincial medical plan recognized Christian Science treatment as the equivalent of medical services.

The Committee is not prepared to recommend that OHIP expand its insurance services to include Christian Science treatment and care, nor did Mr. Fulton request that it do so. It should be noted that if Christian Science treatment and care was an insured service under OHIP, the insurance

companies would be forbidden by law to offer this coverage. Since Christian Science treatment and care is not an insured service, then any properly licensed insurance company and non-profit prepaid medical care organization may provide this coverage on either a group or individual basis.

The Committee suggests that the IBC reconsider its general bulletin quoted above.

14. The Committee recommends that the Insurance Bureau of Canada reconsider portions of its general bulletin concerning Christian Science treatment and automobile insurance that deals with payments for services as requiring that both the insured's attending physician and the insurer's own medical advisor agree that the treatment is essential. The Committee suggests that this portion of the bulletin might be amended by deleting reference to the insured's attending physician and made to read as follows:

“That payments for the service of Christian Science practitioners would be payable when the insured's own medical advisor agrees that such treatment is essential for the treatment or rehabilitation of that person.”

Exclusion of Certain Workers under The Workmen's Compensation Act

Throughout its review the Committee noted many gaps and anomalies in various government plans. One of these is in the Workmen's Compensation Act which excludes certain employees and groups of employees including domestics, the self-employed and casual workers. However, the Committee, aside from *observing* on the matter, will not make any specific recommendations, being content to await the results of papers presently before the Minister of Labour and the Assembly.

C. MEDICAL CARE COVERAGE UNDER PRIVATE SECTOR PLANS

The Committee acknowledges that the insurance companies and the non-profit prepaid medical care organizations have done a reasonably good job of making extended health care plans available to many groups, in particular employee/employer groups, professional associations and other common interest groups. On the other hand, with the exception of Blue Cross and, more recently, Green Shield, the insurance companies and the other non-profit prepaid medical care organizations normally make extended health care coverage available to individuals only on request. Blue Cross and, for the first time in late 1980, Green Shield solicit individual subscribers once a year.

Packaging Extended Health Care Coverage by Insurance Companies

The non-profit prepaid medical care organizations accuse and CAASI acknowledges that in many instances insurance companies will only make extended health care coverage available to groups, in particular medium and smaller size groups, if the policyholder also purchases other forms of insurance coverage such as income protection, death and dismemberment, and group life. The Committee finds itself in a difficult position in regards to this matter. In principle, throughout its studies of the insurance industry it has been on record as being opposed to any form of tied-selling. On the other hand when it comes to medical care coverage the Committee has already acknowledged that residents of Ontario expect to be free from substantially all the costs of medical care at the time of an accident or sickness and during periods of recovery and rehabilitation. To accomplish the latter aim insurance companies have indicated that they can only do so successfully when they sell a “package” to certain smaller and medium size groups.

After considering the matter, the Committee is *not prepared at this time to recommend* that insurance companies be prohibited from selling packages. The Committee will comment further on this matter when it deals with the concerns expressed by both CAASI and the non-profit prepaid medical care organizations regarding premium taxes.

Making Extended Health Care Coverage More Available to Individuals

Historically only Blue Cross has made any effort to make extended health care coverage available to individuals. The Committee finds this unacceptable.

15. The Committee emphasizes that in its view insurers and non-profit prepaid medical care organizations have a responsibility to make extended health care plans more available to those outside recognized groups. Insurers in the past have been successful in developing pooling arrangements for other lines of insurance and the Committee recommends that the insurance industry develop a similar type of pooling arrangement for providing extended health care plans to individuals.

Since the Committee began its hearings, it is pleased to note that Green Shield has introduced a plan similar to that offered by Blue Cross. Both Blue Cross and Green Shield now accept new subscribers on an individual basis for a few weeks each year.

Pre-Existing Conditions

In the course of its studies, the Committee reviewed in detail the various provisions contained in the extended health care plans offered by insurance

companies and non-profit prepaid medical care organizations. The Committee appreciates the rationale for many of the practices followed by the industry such as the deductible or co-insurance features of most extended health care plans which are designed to control costs and abuses. On matters such as these, the Committee has no recommendations or suggestions for changes. However, it is a practice of many insurers to exclude pre-existing conditions or specific conditions under certain extended health care plans. While the Committee acknowledges the industry's explanation for these practices and the possibility of anti-selection, the Committee is also cognisant of consumer needs for protection against what may be the catastrophic costs of medical care to individuals in some instances.

16. The Committee recommends that the industry move to a three-month waiting period as used by OHIP as a generally more acceptable method of controlling abuses and anti-selection.

Insurance Coverage Offered In Connection With The Rental of An Automobile

People wishing to rent automobiles in Ontario are able to purchase at the time of the rental agreement and for the duration of the rental agreement the following coverages:

1) Medical Expenses

A typical rental agency offers to its customer and each passenger coverage for medical expenses to an upper limit of \$1,000.

This medical expense insurance is applicable in Ontario and will pay for medical expenses which are not payable by or recoverable under any government plans.

One rental agency stated that extra-billing by opted-out physicians was not covered. However, since its insurer is located in the United States and may not be conversant with the laws of Ontario the agency could not be sure whether these expenses were in fact being reimbursed.

This agency also stated that to collect the insurance benefit the insured must present all applicable medical bills. The agency will not knowingly duplicate payments if the insured has been reimbursed under a private insurance plan. However, the agency has difficulty enforcing this concept.

2) Collision Damage Waiver

This type of insurance available to the customer in effect offers the customer the opportunity to buy down the deductible on any collision which may result while he or she is driving the car.

3) Accidental Death and Dismemberment

The customer may also purchase accidental death and dismemberment insurance when renting a car. This coverage applies during the term of the rental agreement for accidental bodily injuries and death. A customer's passengers are also covered during the term of the rental agreement while they are driving in, boarding or alighting from the rented vehicle.

The benefits described are payable in addition to any other insurance benefits accruing to an insured.

4) Third-Party Liability

The owner of an automobile in Ontario must purchase third-party liability, this applies to automobile agencies as well. Therefore, all automobiles rented carry with them third-party liability coverage and it is not necessary for a customer to either have his own third-party liability insurance or purchase, at the time of the rental, a third-party liability insurance contract. In cases where damages are in excess of the insurance provided by the third-party liability carried by the rental agency, the injured party would have recourse against both the owner of the automobile and the driver.

Automobile rental agencies do not offer third-party liability coverage as an insurance product to customers at the time of rental.

The Committee has two concerns regarding the foregoing. First, the medical care coverage is not required for residents of Ontario since residents have available to them the basic coverage provided by OHIP and the additional coverage provided with the rental agreement duplicates OHIP's coverage. Second, there is no obligation on the part of the rental agency to inform the person renting an automobile of the amount of the third-party liability coverage the agency carries.

In view of these concerns, the Committee has the following recommendations.

17. Since medical expense coverage provided by automobile rental agencies duplicates coverage available to residents of Ontario through OHIP, the Committee recommends that regulations be passed to indicate that medical care coverage at the time of renting an automobile is not required for residents of Ontario. The regulations should contain provisions for the noting of this fact prominently on all rental agreements and other appropriate forms used by rental agencies.
18. The Committee also recommends that automobile rental agencies be required to disclose the amount of the third-party liability coverage they have and the cost of any additional coverage of which the renter of the automobile may wish to avail himself.

30 Day Limitation on Prescription Drugs

During discussions before the Committee a number of questions were raised concerning the 30 day drug limitation on prescription drugs. Green Shield Prepaid Services Inc. in response wrote the Committee⁽¹⁾ and included the following comments:

“It Has Been Argued That The 30 Day Limitation,

- a) caused inconvenience and sometimes hardship on the elderly and infirm who use medication on a continuing basis, for the reason that they were required to acquire a new prescription or repeat authorization every 30 days
- b) caused an annoyance to the attending physician to supply the authorization every 30 days
- c) caused multiple unnecessary visits to doctor's offices and unnecessary charges to O.H.I.P.
- d) resulted in increased utilization of prescriptions on a per capita basis and generated many additional and unnecessary dispensing fees to be paid to the pharmacist.

Historically, the one month limitation was copied from an early Green Shield quantity limitation of 34 days. Thirty-four days seemed appropriate back in the early 1960's because most medicines were packaged in 100's with a dosage of 3 a day, lasting $33\frac{1}{3}$ days. The logic was as simple as that. However, Green Shield abandoned the 34 day limit when, on the basis of utilization, it proved to be unworkable in the early 1970's and at that time, adopted an “upper limit” quantity assigned by Green Shield to each pharmaceutical. The main criteria for the assigned amount was to coincide with the usual prescribing habits of most doctors with respect to that drug. This remains our procedure for determining quantity limitations of any particular pharmaceutical.

There is no doubt that the “one month's supply” is unsatisfactory to everyone except the pharmacist, who insists that it not be changed to an “as written by the physician” because it is claimed that

1. It would diminish the number of prescriptions written or ordered in each year, thereby diminishing the pharmacist's income correspondingly
2. It would encourage prescriptions for unlimited amounts thereby resulting in:
 - a) Stockpiling
 - b) Diversion to the unentitled
 - c) Trafficking in psychotropic, narcotic and abusable drugs

¹ Letter to James R. Breithaupt, Esq., QC, MPP, Chairman Ontario Select on Company Law; From William A. Wilkinson, Chairman of the Board Green Shield Prepaid Services Inc., July 30, 1980.

The one month's supply is unsatisfactory to most physicians who see it as one more government regulation, and one that interferes with the doctor's right to determine the kind and quantity of medication he wishes to prescribe . . .

In our view the following would resolve the issue:

1. The Ministry request re-affirmation from the O.M.A. that good medical practice should require reassessment of patients on continuing medication at least every 100 days
2. Revise O.D.B. quantities to pay for the "prescription as written" up to 100 days, (rare exceptions to be allowed upon special application), except as 3 below
3. All trafficable psychotropic and narcotic pharmaceuticals, adjudged by an appropriate conjoint Therapeutics Advisory Committee to be abusable and trafficable, to be limited to one month's supply as is presently the case . . ."

In discussions with the association representing pharmacists, they confirmed that they would prefer the 34 day limitation on prescription drugs, mainly for the reasons stated above: the danger of stockpiling; diversion to the unentitled; and, trafficking in psychotropic, narcotic and abusable drugs.

The Committee *understands* that the Ministry of Health authorized an independent study of the entire matter of the limitation on prescription drugs, which report is to be made available later this year. The report is then to be reviewed by the Ministry of Health and a decision made at that time. Under the circumstances, the Committee does not propose to comment on the matter.

D. REGULATION OF THE NON-PROFIT PREPAID MEDICAL CARE ORGANIZATIONS

The question of regulation of non-profit prepaid medical care organizations was brought to the Committee's attention during its hearings and the importance of the matter was emphasized with the recent financial difficulties of Co-operative Health Services of Ontario, a prepaid medical care plan provider.

The Ontario Blue Cross and Green Shield Prepaid Services Inc. in their presentations to the Committee devoted much time to the topic of the principle of prepayment for medical care services and the merits of The Prepaid Hospital and Medical Services Act. Their objectives were two-fold: they wished to ensure first, that the organizations governed by The Prepaid Hospital and Medical Services Act would remain governed by that Act and, second, that these organizations would not be subject to the 2% premium tax that is applied to the premiums for medical care plans sold by licensed

insurers. CAASI, in its presentations to the Committee expressed certain opposing views in regard to this latter matter.

During 1981, The Superintendent made application to the Court under Section 218 of The Business Corporations Act for an order winding up Co-operative Health Services of Ontario. The failure of Co-operative Health Services of Ontario has raised a number of questions concerning the adequacy of regulatory control over non-profit prepaid medical care organizations. It has led to the question whether failure of this organization would have occurred had it been governed by the regulations of The Insurance Act.

In this section, the Committee addresses the concept of prepayment versus insurance, issues relating to the 2% premium tax and regulatory aspects regarding solvency of non-profit prepaid medical care organizations.

The Principle of Prepayment

It is argued that the concept of prepayment of medical care services is not an insurance concept and that the non-profit prepaid medical care organizations offering prepaid medical care plans are not insurance companies nor are they in the business of selling insurance.

Prepayment of medical care services was devised as a system whereby individuals on their own or through groups could budget in advance against the cost of inevitable health needs. In contrast, insurance is defined as a contract for the payment, to an insured person, of a sum of money in the event of some catastrophic event or expense. As these catastrophies are usually rare and unpredictable the insuring agency in effect assumes the insured person's risk for a price.

The Ontario Health Insurance Plan has, since 1959, undertaken to cover basic catastrophic hospital and medical expenses for Ontario residents. Supplemental prepayment plans offered by non-profit prepaid medical care organizations and insurance companies are designed to cover items and services that extend beyond basic needs or are used with predictable regularity; in many cases, the extent of utilization of these services is within the subscriber's own control.

Differences in Medical Care Plans Offered by Non-profit Prepaid Medical Care Organizations and Insurance Companies

The private medical care plans are limited by law to covering only those services not covered by OHIP. Non-profit prepaid medical care organizations and insurance companies effectively offer the same types of plans. They offer: extended health care plans; prescription drug plans; dental care plans and certain other types of plans.

The major difference between the two types of organizations concerns

their methods of marketing and how each determines eligibility for coverage. Insurance companies market all of their plans on a group basis; a person must qualify as a member of that group in order to be eligible for coverage. Medical care plans are not made available by insurance companies for individual subscribers except on a highly selective basis.

The Ontario Blue Cross and Green Shield Prepaid Services Inc. offer certain coverages under extended health care plans to individual subscribers. While there are no eligibility requirements to be met to qualify for coverage, these plans are open to individuals for only a few weeks each year.

As a corollary of the fact that insurance companies essentially only provide extended medical care coverage on a group basis, those eligible for coverage under such plans when leaving the group must, if they wish to maintain coverage, either become eligible for another group plan or apply for individual coverage from either Blue Cross or Green Shield when they open for new subscribers. Employees and other group members who have their master policy with either Blue Cross or Green Shield when they leave the group through retirement, for example, are able to continue their coverage since these organizations will make coverage available on an individual basis immediately without any risk of being without coverage for a time.

The non-profit prepaid medical care organizations feel that the history of their operations shows that the public had a need for the extended medical care plans they offered; that the public need was not served by commercial carriers; that the public need could not be met by standard insurance programs; that the public need was perceived only by those wholly outside the insurance field; and, that this public need was met by the non-profit prepaid medical care organizations. Further, these organizations feel that history supports the proposition that there is a significant difference between non-profit prepaid medical care organizations providing prepayment plans in the health care field and the commercial insurance carriers.

History of Prepaid Medical Care Plans

The first program of prepayment of medical care services was initiated by the Blue Cross in the United States in the early 1930's. The concept soon spread into Canada. Until 1950, the organizations offering prepaid medical care plans were regulated by the Provincial Department of Health. In 1950, The Prepaid Hospital and Medical Services Act was passed and proclaimed in 1951. This Act requires that plans for hospital, medical, surgical or dental services be operated on a non-profit prepayment basis. Prepaid drug plans were initially unregulated; however, by reason of legislative amendment, drug plans are now included in the Prepaid Hospital and Medical Services Act.

The prepayment plans were initially designed to offer groups, and later

individuals, the right to prepay the cost of health care expenses. The public welcomed these types of plans and the number of organizations offering them grew.

The Ontario and federal governments, realizing the need for such a plan, introduced its own universal hospital insurance plan in 1959. The government plan took over virtually all of the coverage previously offered by the private organizations. Coverage provided by private organizations is now restricted to services not covered by OHIP.

The current providers of prepaid medical care plans include a number of insurance companies and four non-profit prepaid medical care organizations: The Ontario Blue Cross, Green Shield Prepaid Services Inc., Quebec Hospital Services Association and The Credit Union Mutual Benefit Association.

Regulation

All non-profit prepaid medical care organizations must be registered under The Prepaid Hospital and Medical Services Act. This Act stipulates that the Superintendent will grant registration if he is satisfied:

- “(a) that the applicant is established as a bona fide association;
- (b) that the contracts and proposed contracts with hospitals, physicians, pharmacists or other persons for the rendering of service to subscribers or members and the contracts or proposed contracts with subscribers or members are fair and reasonable;
- (c) that the applicant has established and has such working capital and reserves as the Superintendent considers adequate; and
- (d) that the rates charged or to be charged to subscribers or members are not excessive, inadequate, unfairly discriminatory between risks or otherwise unreasonable . . .”

The Superintendent has the right to revoke any licence granted to a non-profit prepaid medical care organization if he feels that an organization is not living up to the terms set out in The Prepaid Hospital and Medical Services Act.

The objectives of The Insurance Act are generally similar. However, The Insurance Act requires insurance companies to meet a minimum capital requirement of \$1,000,000 and to deposit securities of at least \$25,000 with the Superintendent.

The non-profit prepaid medical care organizations feel that the capital and reserve requirements under The Insurance Act if made applicable to them would greatly reduce their ability to operate. These organizations feel that the present situation is fair and equitable and that The Prepaid Hospital and Medical Services Act does give the Superintendent regulatory powers which

are adequate and appropriate for the protection of the public. Through the mandatory audits and annual submission of detailed information schedules, the Superintendent is, in their opinion, well able to monitor all the financial and operational activities and to require early corrective measures if he has reasons for concern. The Superintendent has the power to suspend a plan's registration and its ability to underwrite new coverage until its financial affairs are in order, should he deem it necessary.

2% Premium Tax

The presence of a 2% premium tax has caused much discussion among the insurance companies and the non-profit prepaid medical organizations. Organizations governed by The Prepaid Hospital and Medical Services Act are not subject to a 2% premium tax on premiums written, whereas organizations governed by The Insurance Act are subject to this tax. Corporations operating under both Acts have made submissions to the Committee presenting arguments for and against a 2% premium tax.

Arguments of Non-Profit Prepaid Medical Care Organizations

Nine provinces and 45 states in the U.S. in which prepayment corporations are regulated by separate statute do not levy a premium tax on medical care plans offered by the non-profit prepayment corporations. In Canada, only in Quebec is Blue Cross regulated under the Insurance Act and as such a 2% premium tax applies to all Blue Cross premiums as well as to all insurance premiums collected in the province.

The non-profit prepaid medical care plan organizations feel that price competition from the insurance companies in the area of extended health care plans is extensive. They feel that insurance companies are selling these plans as "loss leaders" to help promote the sale, to company groups, of packages containing more profitable items. If the non-profit prepaid medical care organizations were to be governed by the terms of The Insurance Act and consequently subject to a 2% premium tax, they would no longer be able to compete effectively.

Furthermore, the non-profit prepaid medical care organizations feel that a 2% premium tax would be an onerous charge to individuals subscribing to medical care plans. As the non-profit prepaid medical care organizations do not operate on a profit basis, the 2% premium tax would be a direct cost to their subscribers. In the opinion of the non-profits, the increased cost of the medical care plans would tend to restrict availability, particularly to individuals not covered by group plans.

Arguments of Insurance Companies

The Canadian Association of Accident and Sickness Insurers recom-

mends the elimination of the premium tax as applied to the medical care coverage provided by insurance companies. CAASI feels that organizations governed by The Prepaid Medical and Hospital Services Act enjoy a meaningful and unjustifiable competitive advantage because they are not subject to the premium tax which is applied to private insurers' premiums.

CAASI also feels that the premium tax discriminates against residents who, through the insurance mechanism, provide themselves, their families and others with protection against financial hardships which occur as a result of accident, sickness or death. Members of society who voluntarily wish to make provision for protection in the case of accident, sickness or death should be encouraged to do so. The imposition of a 2% premium tax tends to discourage these people from protecting themselves against such occurrences.

CAASI stated in its submission to the Committee that those groups which are large enough to arrange their own insurance needs can do so through "administrative services only" arrangements and through "self-insurance" as a vehicle for avoiding the imposition of the premium tax.

ESTIMATED PREMIUM TAXES
(**\$000's**)

a) Insurance Companies

	1979	1978	1977	1976	1975
Total Estimated direct premiums earned by accident and sickness insurers (all classes of insurance)	<u>626,770</u>	<u>531,300</u>	<u>464,250</u>	<u>387,230</u>	<u>325,010</u>
Estimated 2% premium tax	<u>12,535</u>	<u>10,626</u>	<u>9,285</u>	<u>9,985</u>	<u>6,500</u>
Estimated direct premiums earned by accident and sickness insurers for medical care and dental care insurance	<u>223,350</u>	<u>168,520</u>	<u>132,400</u>	<u>99,500</u>	<u>75,560</u>
Estimated 2% premium tax	<u>4,467</u>	<u>3,370</u>	<u>2,648</u>	<u>1,990</u>	<u>1,511</u>

b) Non-profit prepaid medical care organizations:

	1979	1978	1977	1976	1975
Estimated premiums earned for prepaid medical and dental care plans	<u>201,062</u>	<u>174,800</u>	<u>157,140</u>	<u>140,020</u>	<u>117,910</u>
Estimated 2% premium tax	<u>4,021</u>	<u>3,496</u>	<u>3,143</u>	<u>2,801</u>	<u>2,358</u>

Note: Premium tax is payable on net premiums written, the above estimates of premium taxes have been calculated using estimated premiums earned. Therefore, these estimates should only be used as a guide to indicate the order of magnitude and for comparative purposes as they may not be equal to the actual premium taxes paid or that would have been paid.

Non-profit prepaid medical care organizations are not subject to premium tax. The above figures indicate premium taxes payable if these organizations were subject to premium tax on premiums earned.

Estimated Premium Taxes

The table on the previous page presents an estimate of the total premium taxes paid by accident and sickness insurers in Ontario for the five year period ended 1979. The table also shows the amount of estimated premium taxes that would have been paid by the non-profit prepaid medical care organizations, had they been subject to such tax.

The Committee's Observations, Conclusions and Recommendations

The Committee had great difficulty accepting the arguments made by the non-profit prepaid medical care organizations that extended health care coverage is not insurance but rather should be looked upon as a form of prepayment for medical care. If this were to be the only reason for continuing with a separate governing act for these organizations rather than bringing them under the umbrella of The Insurance Act, the Committee would not be impressed.

Likewise, the Committee had great difficulty in accepting the fact that a 2% premium tax would act as sufficient disincentive to individuals to dissuade them from obtaining extended health care coverage.

The Committee does acknowledge that in the case of employer/employee groups, particularly when the employer pays the entire premium, the 2% premium tax may indeed be sufficient justification for the group to either self-insure or to operate with an administrative services only plan through an insurance company.

The Committee can also appreciate the concern of the non-profit prepaid medical care organizations that if a 2% premium tax were to be imposed on their premiums, they would lose what little competitive advantage they have with groups and would still be at the mercy of the insurance companies if they are permitted to continue to package their extended health care plans with other coverages they are able to provide and which are not available from the non-profit prepaid medical care organizations. The Committee's concern regarding the implications of imposing a 2% tax on the premiums collected by the non-profit prepaid medical care organizations went so far as to lead it to wonder whether such a tax might even lead to the collapse of some or all of these organizations.

The consideration of separate legislation is not confined to matters relating only to the non-profit prepaid medical care organizations. Other forms of insurance, prepaid legal as an example, which are or may become available to residents of Ontario need to be considered at the same time. In a similar vein, throughout its deliberations in matters relating to general insurance, life insurance, retirement plans and now disability income protection where self-insurance is an alternative chosen by some employers, the Committee has had a continuing concern regarding the role the Superin-

tendent should take in supervising such plans in order to ensure that the benefits promised will be available to employees when they are needed.

It is in the context of all of the foregoing that the Committee arrived at its *conclusions* which may be briefly summarized as follows:

- to leave the non-profit prepaid medical care organizations regulated under a separate but stronger act; and
- not to impose a tax on the premiums written by the non-profit prepaid medical care organizations.

Essentially the rationale for these conclusions is that the non-profit prepaid medical care organizations are the only organizations who make a real effort to sell extended health care plans to individuals and as an incentive to continue to do so, the Committee could not justify any change in the premium tax structure applicable to these organizations on their group sales. In addition to these conclusions as they relate to the non-profit prepaid medical care organizations, the Committee also *concluded*:

- every other type of insurance should be regulated under The Insurance Act, including prepaid legal plans, and
- The Insurance Act should be broadened to include administrative services only plans and self-insured plans.

In arriving at these conclusions, the Committee does not intend to pass judgment either for or against the prepaid legal plans. The Committee's concern is only that it wants to see that the provisions of The Insurance Act are sufficient to protect the consumers of Ontario and that plans are solvent and able to provide the promised benefits when required. The Committee does not wish to discourage initiative but wants The Insurance Act made sufficiently strong so that the Superintendent is able to fulfil the role that it believes should be his main function—that of protecting the public.

19. The Committee recommends that non-profit prepaid medical care organizations continue to be regulated under separate statute, The Prepaid Hospital and Medical Services Act.
20. However, the Committee recommends that the Prepaid Hospital and Medical Services Act be amended as appropriate to provide to the Superintendent of Insurance the same powers over the non-profit prepaid medical care organizations as are provided to him under The Insurance Act regarding the supervision of insurance companies.
21. The Committee also recommends that no change be made that would remove the exemption from premium taxes on the premiums collected by the non-profit prepaid medical care organizations.
22. The Committee recommends that, with the exception of the non-profit prepaid medical care organizations, all other insurance type

plans be administered under provisions of The Insurance Act. The Committee has in mind such plans as prepaid legal and association sponsored prepaid dental plans.

23. The Committee recommends that the provisions of The Insurance Act be extended to provide for suitable solvency, reporting and security provisions as may be appropriate in order to provide protection to the potential beneficiaries under all insurance type plans and ensure that the benefits promised will be delivered when required. The Committee envisages that The Insurance Act will be amended as appropriate to ensure that these requirements are extended to, among others, administrative services only plans, self-insurance plans and plans organized by labour unions.
24. It is not the Committee's wish to stifle in any way initiative in the design of insurance type plans and therefore the Committee recommends that the capital and deposit requirements to be applicable to various types of plans be defined in terms that may be appropriate to individual circumstances rather than requiring conformity to stringent and possibly prohibitive capital and deposit requirements made applicable to all.
25. The Committee is not prepared to make specific recommendations concerning the application of premium taxes to all of the plans that it is recommending should now be brought under The Insurance Act. The Committee is prepared to leave the matter as to whether premium taxes should or should not be applicable to administrative services only, self-insurance and union plans to the Minister of Revenue as he may determine is appropriate and desirable.

CHAPTER 23

Financial Protection Against the Costs of Dental Care

A. INTRODUCTION

There is no comprehensive public dental care plan in Ontario as there is for medical care. OHIP covers only specified dental services in hospital that are related to accident or injury. In the Committee's long-range view, it sees a comprehensive dental program as part of a universal integrated disability financial protection system for the residents of Ontario. The Committee realizes, given current economic conditions, this is not possible at the moment.

The Committee acknowledges that the concept of a comprehensive public dental care plan for Ontario is not new, noting with particular interest the comments made by the Hon. Emmett M. Hall, CC, QC, in his report "Canada's National-Provincial Health Program for the 1980's—A Commitment for Renewal".

"Children's Dental Program

In Volume I of the Royal Commission on Health Services (1964) at page 35, the Commission said:

"There should be introduced as quickly as organization and recruitment can be accomplished a dental program for children using the services of dentists and dental auxiliaries. In the first year, say, 1968, all children aged five and six would be entitled to dental examination and restorative services, including, where necessary, referral to orthodontic and other specialists. In the second year, 1969, all children aged four, five, six and seven would be entitled to services, and in the third year, 1970, all children from three to eight. In each of the following years a succeeding single aged group should be added. By 1980, all children up to the age of 18 would be entitled to services and all children then 18 would have had regular dental care throughout their formative years. We should like to see the children's program introduced in all Provinces simultaneously so that children moving from one Province to another do not lose continuity of service. In addition, any Province that has the resources should be encouraged to accelerate the program.

We have no illusions about the difficulties and problems that this decision will create. Financial resources must be made available to attract dental personnel into this program on a large scale.

Furthermore, we are aware of the problems created by the necessity to exclude from the program older children in the program. For this

reason we believe that the program must be financed solely from Federal and Provincial General funds. That means there must be no specific "premium" for this program. We also believe this programme to be so important that it cannot await Federal Government and Provincial Government decisions on the comprehensive health program as a whole and of which this benefit might be considered a part. This program must have one of the highest priorities among all our proposals."

This recommendation has been implemented in varying degrees in the ten Provinces. Newfoundland has had a comprehensive children's program since 1950. Prince Edward Island has had one for ten years; New Brunswick has a limited plan covering children in remote areas; Quebec's plan provides full coverage for children under 16; Manitoba, Saskatchewan and Alberta have well established comprehensive programs and British Columbia is inaugurating a program as of January 1, 1981 which will cover 415,000 children and 290,000 senior citizens."

Further, the Select Committee on Health-Care Financing and Costs under the chairmanship of Bruce McCaffrey MPP in 1978 on page 5 of its report commented:

"For example, half the population of Ontario does not receive regular dental care. Alberta, Saskatchewan, Nova Scotia, Prince Edward Island and Newfoundland do provide a range of dental services not available in Ontario and the Committee recommends that high priority be given to consideration of a school-age dental program in Ontario as an extended health benefit."

The Committee acknowledges that there have been some efforts made in recent years to improve dental care particularly among children in remote areas. These efforts have required the cooperation of both the government and the Ontario Dental Association and although there have been some criticisms by local dentists, the dental bus program in the remote areas, particularly of Northern Ontario, is in the Committee's view a commendable step.

The Committee is of the *unanimous opinion* that the next universal plan that should be instituted in Ontario should be one covering dental care. The Committee believes that the most appropriate way to institute such a plan would be to phase it in, in a manner similar to that suggested by the Royal Commission on Health Services in 1964 by beginning with young children say four to seven the first year and then adding one year to each succeeding year until all children up to the age of eighteen would be entitled to the service on a regular basis. If it is necessary, the Committee would be prepared to recommend that basic preventive and maintenance dentistry should be given first priority but that as soon as is practicable orthodontic services for children be added as well, with major restorative procedures added as circumstances

permit. Alternatively, the Committee might suggest that the full range of services be provided in hardship cases.

26. The Committee recommends that the Minister of Health give high priority to the introduction of a comprehensive dental care plan for children of Ontario, phasing in the plan as may be appropriate with the ultimate aim of covering all children under the age of eighteen for preventive and maintenance dental work, orthodontic services and major restorative procedures. The Committee recognizes that current economic conditions may make it impossible to introduce such a plan at the moment but it believes that the Minister should undertake the accumulation of statistical and other data necessary to develop an implementation program for such a comprehensive dental plan even though it may be impractical to introduce such a plan immediately.

B. DENTAL CARE COVERAGE UNDER GOVERNMENT PLANS

Many of the Committee's observations regarding its concerns, conclusions and recommendations about the government medical care plans in Ontario apply generally to the government dental care plans available to residents of the Province. The government dental care plans are far less comprehensive than the medical care plans. The only universally available dental care plan is provided by OHIP and it covers only specified dental services in hospitals that are related to accident or injury. Nevertheless, the following observations and recommendations are made with the intent of pointing a direction for improving the government plans and reducing the anomalies the Committee observed.

Excess Billing by Dentists Over The OHIP Schedule of Fees

OHIP generally provides for in-hospital dental care services according to a schedule of fees. This Schedule of Fees is presently on average about 67% of the Ontario Dental Association Schedule of Fees issued by the Association for the guidance of dentists. If the dentist performing services for a patient is "opted-out" of OHIP for that patient, the patient is liable for the excess billing by the practitioner. As for all other OHIP services, residents may not purchase extended health care coverage to pay for any portion of OHIP insured services.

The Committee has expressed its deep concern over the entire matter of excess billings by doctors and the grave consequences to the basic medicare concept as operating in Canada today if excess billing is permitted to continue.

27. While excess billing by dentists is of far less significance than excess billing by doctors to residents of Ontario and to the concept of

universal medicare, the Committee's concerns extend to the opting-out of dentists and the excess billing by them. The Committee stresses the importance of resolving the current problem and ensuring reasonable access to insured services by insured persons under OHIP while at the same time providing reasonable compensation for insured services to practitioners. The Committee recommends that the government through OHIP and the dentists take steps immediately to arrive at a mutually acceptable schedule of fees for services and ensure that Medicare continues for the benefit of the residents of Ontario.

Anomalies in Dental Care Provisions Under Various Government Plans

Eligible workers injured at work will have all of their dental care costs covered by workers' compensation. Likewise, those injured in automobile accidents in Ontario will have all of their dental care costs covered under the accident benefits provision of the compulsory automobile insurance coverage. Further, victims of crimes may be paid compensation for dental expenses including dentures providing there is no duplication of benefits. On the other hand, residents of the Province generally have available to them only limited dental care coverage as provided by OHIP which is generally limited to in-hospital services provided by dentists where these services are required as the result of accident or injury.

Similar anomalies in the coverage provided in these various plans was referred to in the Committee's comments concerning medical care. These comments are equally appropriate to dental care.

28. The Committee repeats its recommendation that the aim in Ontario should be for a common level of benefits for all residents including dental care services without regard to the cause of the need for these services. In due course, a comprehensive disability income protection system for the residents of Ontario should include dental care. The Committee has already expressed the view that the place to begin is with a comprehensive plan for children with a second priority given to specific hardships cases.

When dealing with the general subject of anomalies in the treatment of residents of Ontario as regards dental care plans, the Committee noted the special provision included in certain social assistance programs:

- under provincial long-term Family Benefits Assistance, children get free basic dental care from the dentist of their choice to include examinations, fillings, x-rays, extractions, fluoride treatments, anaesthesia and some restorative services;
- parents get emergency aid only
- everyone gets free OHIP coverage.

- under municipal short-term General Welfare Assistance, provision is made for dental services as required including dentures and appliances.

The Committee could not help but *observe* on the differences in treatment of those requiring social assistance and other residents regarding medical care coverage and dental care coverage. Basic medical care coverage is available to all residents of Ontario through OHIP. Dental care coverage is available to those requiring social assistance, either through OHIP or specific social assistance plans. No comprehensive dental care plan is available to many residents of Ontario and in particular, the working poor and the self-employed.

These anomalies merely serve to reinforce the Committee's previous recommendations.

29. The Committee recommends further that the comprehensive plan it is recommending begin with all children in the Province should be designed on the basic premise of a common standard of dental care for all.

Deductibles or Co-insurance for Dental Care Services

Any discussion concerning the introduction of a dental care plan must be dealt with in the context that dental services are frequently more discretionary than is the case with medical care. In this regard, therefore, a rationale can be developed, particularly under a universal plan, for a minimum deductible or co-insurance and possibly also a maximum annual limit. The dual intent of such provisions would be to control costs and minimize abuses. The maximum annual limit might be designed to control not only total costs but also the costs of "cosmetic services".

While the Committee has no specific recommendation concerning the control of costs, either through the use of deductibles, co-insurance or the annual limit on services, it *recognizes* that any or all of these matters will be needed to be considered with the introduction of a comprehensive plan in Ontario and some or all may, in the discretion of the Minister of Health and the Assembly, be a necessary part of any plan.

C. DENTAL CARE COVERAGE UNDER PRIVATE SECTOR PLANS

Insurance companies and the non-profit prepaid medical care organizations may only design plans to provide dental care coverage for those services not covered as "insured services" by OHIP. Both the insurance companies and the non-profit prepaid medical care organizations have designed plans that are available to residents of Ontario through groups such as employer/employee groups and association groups.

Blue Cross attempted to introduce on an experimental basis a dental care plan available to individuals in two selected counties of Ontario. The plan was unsuccessful and is no longer being offered. Blue Cross was unable to establish a premium structure that would both ensure the viability of the plan and attract participants. No other insurance company or prepaid medical care organization makes dental care coverage available on an individual basis. The Committee recognizes the problem the industry faces in making coverage available on an individual basis and indeed was led to wonder whether a universal plan could ever be made available unless it was a government plan.

Unfortunately, the Committee is unable to obtain any accurate information as to the number of residents of Ontario covered by group plans and conversely, the number of residents not covered by any plan. Neither the present statistics maintained by the industry nor by the Superintendent of Insurance can be analyzed to provide a reasonable approximation of Ontarians covered by dental plans. The Committee is satisfied, however, that there are a great many residents who must rely on their own resources for any dental care they require. As a consequence, the Committee suspects that there are a great many residents who do not visit their dentist unless it is an emergency.

The Committee is impressed with the growth in the number of dental care plans in Ontario in recent years. The insurance companies and non-profit prepaid medical care organizations are to be commended for their efforts and the Committee encourages them to continue to be innovative in the design of such plans so as to increase their availability to more of the residents of Ontario.

30. The Committee would be pleased to see the private sector develop a pooling arrangement of some kind whereby it might be able to extend dental care coverage to those who do not make up appropriate affinity groups under present group plans. The Committee encourages and recommends that the private sector demonstrate initiative in this regard in view of the aim that it has expressed for a comprehensive basic plan available to all residents of Ontario in the future.

Pre-existing Conditions and Waiting Period

The prepaid dental care plans now in place, normally employer/employee group plans, usually require six month full-time service before an employee becomes eligible for benefits. Further, plans frequently exclude pre-existing conditions.

In the same way that the Committee encourages the industry to be innovative in the extending of dental care plans to cover as many residents of Ontario as practical, it also encourages the industry to review carefully the

restrictions it applies both in making plans available to members of groups and to the eligibility for benefits. To repeat, the Committee's ultimate aim would be for basic dental care to be available to all residents of Ontario regardless of the cause of the need for the services involved.

In this context, the Committee also noted that the extended health care plans offered by insurers and non-profit prepaid medical care organizations normally cover dental care when necessitated as the result of an accident which occurs when the agreement is in force and some refer to the cause of the accident as being a "direct accidental blow to the mouth". Generally plans stipulate that they will cover one set of artificial teeth when natural teeth have been damaged but would not include periodontia or orthodontia treatments or the repair or replacement of artificial teeth. All plans stipulate the period of time after the accident in which treatment must commence.

The Committee can appreciate some of the reasons for the stance taken by the industry. However, it can also appreciate that rigid rules can often produce unjustified hardship on the injured person. The Committee has in mind, for example, growing children who sustain an injury that may require ongoing treatment for some years including the replacement of artificial teeth and, in other instances, that the application of a time limitation for the commencement of certain services may be unreasonable. It may, for example, be wasteful to have work done on the teeth of growing children when the teeth are going to be replaced later and yet the work will not be covered if the work is delayed.

31. The Committee recommends that insurers and the non-profit prepaid medical care organizations take a more flexible attitude in the enforcement of standard conditions in connection with the settlement of claims for dental care. In particular, the Committee recommends the industry apply more individual judgment regarding the duration of treatment and limitation for the commencement of services in the case of children.

Sponsored Dental Care Plans

Some unions have set up their own dental care plans, either clinics or capitation plans. The Superintendent of Insurance for the Province has expressed some concern regarding these plans in that they are beyond his supervision as unions are specifically excluded from The Insurance Act—reference Section 21, a portion of which reads as follows:

- “(4) The following shall not be deemed insurers within the meaning of this Act or required or entitled to be licensed as such:
 3. a trade union in Ontario that under the authority of the incorporating act or charter has an insurance or benefit fund for the benefit of its own members exclusively”

32. The Committee recommends that appropriate revisions be made to The Insurance Act to remove the exemption of trade unions and to provide the Superintendent with the powers, the Minister believes he should have over any insurance type plan, to protect the consumer regarding the solvency of such plans and to ensure benefits provided to the participants in such plans will be delivered when required. The Superintendent should have authority to require accurate reporting of information and compliance with appropriate solvency, deposit or guarantee requirements as the Superintendent might deem appropriate. Essentially, the Committee believes that if money is advanced in the expectation of receipt of services to be delivered later, there is a role for the Superintendent.

CHAPTER 24

Considerations Regarding a Comprehensive Disability Income Protection System

A. INTRODUCTION

There is a proliferation of disability financial protection plans in operation in Ontario and throughout Canada. There is, however, no overall "system" and as a consequence, in the case of loss of income some will need to rely on social assistance to provide minimal support. The Committee has already expressed its view that there is a need for a comprehensive disability financial protection system for residents of Ontario.

It is in the area of income protection that the Committee feels most strongly there must be a comprehensive integrated system and that attempting to patch the existing plethora of plans will result in token improvement only. The Committee puts particular emphasis on income protection because of the definition it places on "income protection" and what such protection is capable of doing for the disabled and their dependents. Income protection permits the maintenance of a standard of living; the ability to discharge responsibilities; a sense of independence; and, generally freedom of action. If one has income protection one is likely to be able to retain a sense of independence and individuality, retain self-esteem, a sense of worthiness and generally to enjoy a quality of life.

The critics of the present disability income protection system in Ontario are numerous. The Superintendent of Insurance, CUPE and other witnesses who appeared before the Committee were critical. Criticism of an unco-ordinated system of disability income protection is not confined to Ontario but has been expressed in other provinces of Canada and other countries of the world.

As the Committee conducted its review it was struck first by the gaps, inconsistencies and anomalies in the treatment of the income protection provided to disabled residents depending not on the severity or duration of the disability but upon the circumstances which caused the disability or the particular social or economic circumstances of the individual involved. The income protection available to a worker injured at work, in an automobile accident, by criminal act, at home or at recreation are all different even though the injury sustained by the worker might be the same in each case. Many workers in smaller and medium size organizations, the self-employed, students, homemakers and the unemployed are treated differently again than most workers employed by larger firms. Blue collar workers are frequently treated differently than white collar workers.

33. The Committee recommends that the focus of disability income protection be shifted from the cause of the disability to the severity

or duration of the disability. Essentially, the problem with the present system is that the eligibility and level of income protection is frequently dependent upon how or where the disability occurred rather than the disability itself. The focus must be shifted from “cause—the how and where”—to the “degree and extent and what happened”.

Even though the principle of a comprehensive disability income protection plan for residents of Ontario is attractive, the work the Committee has done on the scheme has alerted the members to the many diverse problems involved in the development and implementation of a proper system. Indeed, some of the problems may be intractable or solutions may not be socially acceptable. The Committee nevertheless feels that the program is desirable and it should be a goal for the Province.

The Committee also reached *consensus* on another matter concerning a comprehensive disability income protection plan—while it might be preferable to have the initiative taken in the development of such a plan at the federal level that to rely on the federal government would be a dereliction of duty on the part of the Government of Ontario since the problems are in the Province and can, with initiative, be resolved here. The Province cannot avoid the issue by saying the solution can only be on a Canada-wide basis. Something has to be attempted by the Province to improve a situation which all agree requires government attention.

34. The Committee recommends that an interministerial committee be established as soon as practical to examine the problems and possible solutions to the introduction of a comprehensive disability income protection plan for residents of Ontario.

The Committee acknowledges that an interministerial committee may not be able to resolve all of the problems and that it may be appropriate to establish a Royal Commission to assist in the development of solutions.

With this recommendation in mind, the Committee having had an opportunity to give consideration to the components that might be appropriate for a comprehensive integrated disability financial protection plan for the residents of Ontario, submits in the remainder of this chapter its comments regarding a number of aspects of such a plan.

The Committee must make it clear that detailed consideration of a comprehensive integrated financial protection system for Ontario is beyond the scope of its present mandate and its ability. In particular, the Committee has neither the authority nor the resources to commission a costing study that would be necessary to weigh the costs of the benefits being suggested as compared with the costs of present benefits which may be provided either through government plans, plans organized by the private sector or paid for by the residents of Ontario out of their own resources.

B. THE UNDERLYING PRINCIPLES AND PHILOSOPHY OF A COMPREHENSIVE DISABILITY FINANCIAL PROTECTION SCHEME

A Comprehensive Plan

The Committee has referred previously to one of the more important principles of a comprehensive disability financial protection plan for residents of Ontario as being concerned with the degree or extent of the disability of the individual rather than the cause of the disability or how or where it occurred. Therefore, all disabled whether the source of their disabilities is prenatal or congenital in nature, caused at work, on the road, at home or at recreation should be covered under a comprehensive plan. A comprehensive plan would cover children, students, homemakers, workers, the unemployed, the aged, the criminal—everyone. A comprehensive disability financial protection plan would cover all residents of Ontario 24 hours a day.

Self-Interest

A second aspect of the underlying philosophy for a comprehensive disability financial protection plan for residents of Ontario is recognition that the introduction of such a plan is in the self-interest of all of the residents of the Province. Taking as a given, the humanitarian justification for a comprehensive disability financial protection plan, which few will dispute, there are also economic reasons for such a plan with ultimate benefit to all residents of the Province. Residents of Ontario are “paying the costs” now of a disability program but are not getting full value for their money. There are a conglomeration of plans making up the present “system” all of which have a measurable dollar cost. These include workers’ compensation; unemployment insurance sickness benefits; death and disability benefits of the C.P.P. and other retirement pension plans; group and individual policies of insurance; the accident benefits provisions of the compulsory automobile insurance; compensation for victims of criminal acts; veterans’ benefits; life insurance; welfare; tort liability and charitable relief. But there are also the costs that are not so easily measured in monetary terms. The loss to the economy because of the inefficiencies and gaps in the present unco-ordinated and fragmented “system” and the resultant lack of concern with the well-being of the work force. A comprehensive disability income protection plan designed to maximize the productive contribution of the disabled to the economy would benefit all residents.

Rehabilitation

Another extremely important principle of a comprehensive disability financial protection scheme for Ontario concerns the rehabilitation of the disabled. The Committee will deal with the subject of rehabilitation in considerable detail in Chapter 26. Suffice to say that a comprehensive disability financial protection scheme must have as one of its keystones not

only physical rehabilitation but be extended to be a comprehensive rehabilitation program ensuring that psychological rehabilitation, vocational rehabilitation, educational rehabilitation and social rehabilitation are all co-ordinated as a total rehabilitation concept in the program.

Level of Income

A fourth underlying philosophy of a comprehensive disability financial protection plan for residents of Ontario relates to the level of income protection to be provided to the disabled. The concept of the plan should not be to provide token income protection or a basic level of income designed merely to sustain the disabled. Rather the concept of the plan should be to provide compensation at levels geared to maintain the living standards of the disabled and catering to their social and economic needs by the maintenance of earnings at a level approximating that being earned at the time disability occurred. The provision of income related benefits for lost income should be provided to the disabled throughout the entire period of his or her incapacity.

Administration

The final principle on which a comprehensive disability income protection plan for residents of Ontario must be based relates to its administration. The plan must be fair, equitable and efficient. It must be well administered.

C. THE EXTENT OF A COMPREHENSIVE DISABILITY FINANCIAL PROTECTION SYSTEM

The breadth of a comprehensive disability financial protection program could be construed as being very wide to cover income protection, medical care, dental care, safety and prevention and rehabilitation. In order to minimize the confusion in dealing with this very difficult subject, the Committee does not propose to deal any further in this chapter with matters relating to medical care and dental care having commented on these subjects in the previous two chapters. Likewise the Committee will defer its comments on safety and prevention until Chapter 27. Therefore, the comments which follow will relate only to matters concerning income protection and rehabilitation.

D. A COMPREHENSIVE DISABILITY FINANCIAL PROTECTION SYSTEM—SOME INCOME PROTECTION AND REHABILITATION CONSIDERATIONS

Who Should be Covered by a Comprehensive Disability Income Protection System?

The *goal* of the comprehensive disability financial protection system should be to provide coverage to every resident of Ontario. There is no

justification for any exclusions from a comprehensive program. Therefore, such a program should cover all workers, the self-employed, farmers, those with congenital defects, the retired, the aged and all non-earners including homemakers, students and children.

The introduction of a comprehensive plan to cover all residents of the Province immediately would likely be impractical. The Committee recognizes that the work involved in the design and setting up the administrative procedures for such a plan will take a number of years.

35. The Committee recommends that it may be appropriate to introduce a comprehensive disability financial protection plan for the residents of Ontario in stages. One way is to introduce the program to different groups of people. For example, in this "International Year of Disabled Persons", the Committee considers it reasonable to introduce a comprehensive income protection plan for all those with certain congenital defects. It might be worthy then to design and implement a comprehensive program for the self-employed, although the Committee recognizes that this is a particularly difficult area. Another way of introducing a comprehensive plan by stages would be to follow the lead taken by some other jurisdictions who have introduced a comprehensive plan covering all those disabled by way of accident as a first stage to be followed at a later stage with a program designed to cover those disabled as a result of sickness.

Coverage for Residents While Out of the Country

The plan as envisaged by the Committee is one whereby the residents of Ontario would be protected by a comprehensive system of income protection during disability.

36. The Committee recommends that any comprehensive disability financial protection plan would be applicable to residents whether they are at home or out of the country.

What Disabilities Should be Covered Under a Comprehensive Disability Income Protection Plan?

In the broad sense, the Committee believes that there should be no exceptions to the disabilities that would be covered under a comprehensive plan and in general no limitations on the cause of those disabilities. The Committee, in making this statement of general principle recognizes that there may be certain contentious causes of disability that may make some exceptions necessary. The most obvious example is disability as a result of self-inflicted injury.

37. The Committee believes that the concept of a comprehensive disability financial protection plan for Ontarians should be that there

will be as few exceptions as possible regarding the cause of disability and these only on the basis of clear principles.

Financing a Comprehensive Disability Income Protection Plan for Ontarians

Both the present New Zealand plan and the proposed plan of the Australian Labour Party envisage that a comprehensive disability financial protection plan would consist essentially of three separate plans—an earners' plan; a motor vehicle accident plan and a supplementary plan for those disabled other than in work-related incidents or as a result of motor vehicle accidents. The Committee can *see much merit* in basing the financing of any comprehensive plan in Ontario on the concept of contributions being made as if there were a separate workers' plan, a separate automobile plan and a third plan paid for out of general tax revenues. However,

38. In a comprehensive financial protection system, the Committee cannot see any merit in attempting to maintain separate and distinct funds and account for the operations of each fund separately. On the contrary, the Committee believes that the premise of consistent and uniform treatment for all residents requiring disability income protection would be served better if the plan were treated as one plan and accounted for on that basis.

Financing a Comprehensive Plan

The Committee commented above on the fact that it does not believe that Ontario should follow the practice adopted in certain other jurisdictions concerning maintaining separate disability income protection funds for earners, for those disabled as a result of automobile accidents and for all other disabled.

39. In this connection, however, financing the plan is another consideration. Some are of the opinion that the most reasonable approach would be to finance the entire plan out of general taxation. Others believe that financing a comprehensive plan should be based upon a continuation of the principles of workers' compensation premiums being paid by employers and automobile insurance premiums being paid by the users of motor vehicles. On balance, the Committee recommends that the principle of three sources of financing—employers' contributions similar to workers' compensation premiums; motor vehicle users' contributions similar to automobile insurance premiums; and, general contributions by way of taxation as is the case for many of the present public programs.

The Committee arrived at its conclusion concerning this method of financing of a comprehensive plan with three main factors in mind:

- 1) Continuing financing a portion of the plan by way of employer contributions approximately equivalent to the present workers' compensation premiums would continue to provide a method whereby incentives could be provided to employers to adopt safety and prevention programs designed to minimize work-related accidents of employees.
- 2) The general principle that the charges to be made against the general revenues of government should be kept to a minimum.

Some Committee members express the view that the financing of the plan should be designed with the concept in mind of "how much cannot be a burden on general revenues?" As an example of this latter concept if medical care were to be included in the comprehensive plan, the special form of financing presently used by OHIP might be retained although as noted the Treasurer in his most recent budget speech has indicated that he is prepared to consider alternatives.

- 3) The Committee sees a relevance in having special categories of financing and does not see that there would be objection to the concept of maintaining the principles of workers' compensation premiums and automobile insurance premiums. Workers' compensation premiums are accepted as a cost of doing business. Likewise, automobile insurance premiums are accepted as a cost of the use of motor vehicles. Indeed, the Committee can see that there may be merit in continuing the concept of delineation into other areas of financing any supplementary plan rather than accepting automatically that this financing need come from general taxation. The Committee acknowledges that a great deal of thought would have to be given to the financing of a supplementary plan but believes that those charged with the responsibility of designing the details of such a plan should give careful consideration to the possible delineation of segments of the plan from the point of view of financing with the concept of relating financing to benefits and the impact on safety and prevention of a well-conceived funding mechanism.

The Committee re-emphasizes the view expressed above that the concept of separate financing should *not* be carried through to maintaining separate funds from which the payment of benefits would be made and related in some way to the cause of disability of an individual and to a particular method of financing of the total plan.

Administration of a Comprehensive Disability Income Protection Plan

Many who have studied the operations of a comprehensive disability income protection plan have concluded that it would have to be administered by government. The Committee does not accept this concept as a necessary

prerequisite. It does, however, *acknowledge* that the administration of such a plan would require a regulatory body to oversee its administration with a major aim to avoid disputes and the need to resort to the courts to adjudicate on matters relating to the plan with the expense that would be involved in such proceedings.

The entire matter of the most appropriate method of administering the plan would need much study and would, of necessity, be an early task for an interministerial committee of the government in considering an appropriate design for a suitable plan for Ontario.

A Comprehensive Disability Income Protection Plan and the Tort System

The workers' compensation system as presently operating in Ontario is based on the underlying concept that the worker gives up his right to sue for negligence in return for the benefits provided automatically under the plan for those injured while at work. The tort system in Workmen's Compensation Board legislation, for all practical purposes, is gone.

The compulsory automobile insurance legislation in Ontario is in effect a modified no-fault system with the result that the tort system is no longer of the same importance in settling automobile claims as it was in the past.

Many who have appeared before the Committee and who have written on the subject of a comprehensive disability income protection plan conceive of the elimination of the tort system with the introduction of a comprehensive plan.

While the Committee acknowledges that a move toward the elimination of tort and acceptance of the principle of no-fault is worthwhile in considering a comprehensive disability income protection plan, it is not convinced that this is a necessary prerequisite. There is much evidence as in the case of workers and those injured in automobile accidents to indicate that a comprehensive system can be operated either without the tort system entirely or with a modified no-fault system. This does not in the Committee's view however, lead to the automatic conclusion that tort liability should be eliminated without much more study in the design of a comprehensive plan. The Committee believes that each type of case must be looked at very carefully to see whether the tort system should disappear or whether a form of subrogation should be designed. With subrogation the party would of course be protected under the comprehensive disability income protection plan but the plan itself would be able to resort to the law of negligence in any action against parties found at fault in causing a disability. The case of product liability is a particularly difficult one and would need special attention.

During its enquiry into automobile insurance the Committee gave detailed consideration to no-fault-automobile accident compensation. In-

interested readers are referred to the Committee's Second Report on Automobile Insurance, Part II, Chapters 5 through 8 and Background Study One appended to that Report. Based on its review the Committee recommended, although the Committee was not unanimous, that "fault" no longer be the fundamental factor to be considered in determining whether compensation should be paid for motor vehicle losses.

The Committee was particularly impressed with the capacity of no-fault systems to compensate *all* victims, regardless of fault, rather than paying only the relatively innocent. It is also impressed with the capacity of no-fault systems to reduce adjusting and settlement costs by minimizing fault investigation, so that a significantly larger portion of the premium dollar will be returned to the public in claims payments.

Having reached its conclusion in favour of the general no-fault principle, the Committee then considered the more specific area of compensation for bodily injury. The Committee observed that the advantages of no-fault were even more compelling in this area than in any other. It therefore concluded that Ontario should establish a full no-fault program of bodily injury compensation for economic loss and that the new program should supersede the present Accident Benefits coverage.

The Committee went on to explain—

"Turning from questions of general principle to more specific matters, the no-fault bodily injury programme which the Committee recommends for Ontario should include the following detailed characteristics:

- (a) The no-fault bodily injury compensation programme should define all the various economic losses for which compensation is to be paid and the limits (if any) to be imposed on each type of compensation. *All* victims should then be entitled to recover from their insurers (or from the Motor Vehicle Accident Claims Fund, if there is no insurer) to the full extent provided for in the programme. The victim will neither need, nor be able to obtain, recovery from the other driver, or from the other driver's insurer.
- (b) Compensation for economic losses suffered should include:
 - (i) medical expenses without any monetary limit;
 - (ii) rehabilitation expenses without any monetary limit;
 - (iii) partial or total loss of income should be re-imbursed, subject to a reasonable weekly maximum amount. However, there should be no ceiling in the duration of payments, other than the time required to get back to work;
 - (iv) Where there is no *literal* loss of monetary income, but there is nevertheless a loss of services, payment should be made to cover the actual cost incurred. Such compensation should be subject to a reasonable weekly maximum.

- (v) death benefits should include any reasonable funeral cost and benefits payable to survivors in accordance with a scale of the sort that is now in effect for Accidents Benefits coverage.
 - (vi) if the spouse or dependants have actually suffered a loss of support that exceeds the lump sum benefits provided of in (v), the excess should be paid to them in periodic payments that may be revised or terminated in the event of the recipient's death or re-marriage or the expiration of the period during which the deceased would have provided support to such dependants. Such payments should be made subject to a reasonable weekly maximum amount.
- (c) The programme to be established should provide for the making of instalment payments in order to provide flexibility.
 - (d) The Committee anticipates that its proposed no-fault programme will reduce disputes over compensation to a minimum—certainly far below the present level. However, adequate provision should be made for the settlement of such disputes as may arise and so the present arbitration provisions of the standard policy should be retained, together with a full right of resort to the courts.
 - (e) Compensation should be extended to provide for the needs of all persons suffering economic losses arising from a motor vehicle accident. In this regard the needs of the spouse and dependent children of the injured driver must be considered. Accordingly, compensation should not be denied to those injured persons who were involved in the commission of a criminal offence such as escaping arrest or who were driving while their ability was impaired through the use of alcohol or drugs. The Committee has concluded that compensation should cover such instances, so that economic losses arising from the motor vehicle system are borne within that system, rather than being borne by other systems such as O.H.I.P.’’

The Committee reiterates that while it believes each type of case has to be looked at on its own merits, it acknowledges the advantages of the general concept of a no-fault system.

- 40. The Committee repeats the recommendation contained in its Second Report and recommends that as a general concept “‘fault” no longer be the fundamental factor to be considered in determining whether compensation should be paid in the case of losses due to accident or disability.

Periodic Payments Versus Lump-Sum Settlements

A fundamental principle of a comprehensive disability income protection plan should be the compensation of disabled on the basis of periodic payments rather than by way of lump-sum settlements.

41. The Committee has previously indicated that it is not prepared, at this time, to recommend the elimination of all lump-sum payments although it does believe that periodic payments is the most satisfactory way of paying claims for all concerned.

Taxation of Disability Income Benefits

The Committee comments below on its view on the level of benefits that should be paid under a comprehensive disability financial protection plan. As regards income tax on these payments—

42. The Committee recommends that periodic benefits should be taxable in the hands of the recipient. On the other hand, if a level of lump-sum payments is retained in the plan to compensate victims of injury for pain and suffering and loss of amenities, the Committee believes that these lump-sum payments should be non-taxable.

The Committee emphasizes again that it would anticipate that there would be very few lump-sum payments under a comprehensive plan when introduced in Ontario.

Level of Benefits

The Committee believes that the principle of a comprehensive disability financial protection plan should be to provide income benefits for the full amount of the disabled person's lost income. The Committee recognizes that in the case of workers some of the costs that would normally have to be borne to earn income would not be necessary during a period a disability. Therefore the Committee is prepared to acknowledge that a percentage of normal earnings, say 85-90%, might be appropriate with the difference between 100% and the amount chosen designed to recognize the proportion of those earnings that would usually be laid out to earn the income and that would not be required as long as the disability continues.

43. The Committee recommends that an essential provision of a comprehensive disability financial protection plan be to provide for benefit payments to the disabled at a high maximum level that would be closely related to the normal earnings of anyone disabled in the Province regardless of the level of earnings reached during employment. The concept of the plan cannot be built on one of providing basic or minimal income protection.
44. In this connection, the Committee further recommends that, in the case of homemakers and others not in receipt of earnings, income benefits be based on notional income levels as future studies may indicate may be appropriate.

Indexing of Benefits

The Committee recognizes that the recipients of disability benefits need to have the purchasing power of their income protected, therefore—

45. The Committee recommends that the design of any disability income protection plan provide for the automatic adjustment of benefits on a regular basis with such adjustments possibly based on increases in the cost of living or increases in average industrial wages. The Committee's recommendation in this regard is tempered by a very real concern it has concerning indexing benefits and that by the process of such indexing, it is "institutionalizing inflation".

Death Benefits and Funeral Expenses Under a Comprehensive Plan

46. The Committee believes that provision should be made in any comprehensive plan for the payment of reasonable funeral expenses.

It has been suggested by some that the level of benefits under present government plans, generally \$1,000, may not be realistic in view of recent increases in funeral costs.

47. The Committee also recommends provision be made in any comprehensive plan for the payment of modest death benefits to provide for the transitional adjustments of survivors.

Extended Income Protection Coverage

The Committee has commented earlier on its view that the level of benefits to be provided under a comprehensive disability financial protection plan should have a high maximum designed to provide income protection to those who become disabled while earning even a substantial level of income. Nevertheless, any comprehensive plan will, in all probability, anticipate a maximum level of benefits.

48. The Committee recommends that individuals be permitted to purchase insurance for additional coverage that they may consider necessary in their particular circumstances over the maximum level of benefit payments stipulated in the disability financial protection plan.

Duration of Benefits and the Termination of Benefits

The concept of a comprehensive disability financial protection plan for Ontarians should be that benefits will only terminate at age 65, at death, or when the disabled person is fully rehabilitated. In the Committee's view this is one of the main issues involved in the proper design of a comprehensive disability financial protection plan. The keystone must be in establishing an appropriate definition for disability and then establishing a satisfactory procedure for determining when a recipient of benefits has been fully rehabilitated and, as a consequence, no longer in need of income protection. The Workmen's Compensation Board presently has established procedures

that are adequate in most circumstances in dealing with medical rehabilitation.

49. The Committee recommends that, in addition to the medical rehabilitation of the disabled, the design of a comprehensive plan for Ontarians give much more consideration than has been the case in the past to other aspects of rehabilitation, in particular psychological, vocational, educational, recreational and social rehabilitation.

In order to upgrade rehabilitation in a comprehensive disability financial protection plan, recognition must be given to the special skills required to determine when rehabilitation is attained and benefits are to be terminated. The need for individual assessment or as close to it as is practical, is necessary. The thrust must be for the equitable treatment of all disabled before they are considered rehabilitated.

The Committee comments more fully on matters relating to the rehabilitation of the disabled in Chapter 26.

The Definition of Disability Under a Comprehensive Disability Financial Protection Plan

The Committee *recognizes* that the definition of disability under a comprehensive plan is a matter of vital importance. The Committee does not feel that it is qualified to suggest an appropriate definition at this time. It believes that much additional review and study is necessary before an appropriate definition can be prepared. While a number of alternatives were presented to the Committee during its hearings and were considered by the Committee during its deliberations, the Committee is not prepared to comment on any of the possible alternatives.

Determining Partial Disability

The Committee is in favour of the concept of a Committee of Evaluation capable of bringing skilled judgmental assessments to the determination of partial disability. The Committee rejects and is pleased to see that Professor Weiler has recommended the elimination of "meat chart" assessment procedures.

50. In matters relating to the rehabilitation of the disabled, the Committee reemphasizes the theme that it believes is basic to a well-conceived, comprehensive disability financial protection program that of seeing that assessments are individualized and take into account the whole person.

Waiting Period

The Committee believes that the design of a comprehensive disability financial protection plan should envisage a waiting period before benefits would be paid from the plan to those sustaining injury or becoming sick.

51. The Committee recommends that with the introduction of a comprehensive plan in Ontario, employers be required by law to continue to pay injured or sick workers for the first few days of their disability so long as there are adequate safeguards provided to prevent abuse by employees.

Appeals

Any comprehensive disability financial protection plan to be instituted in Ontario must provide an appropriate appeal mechanism against the decisions of those responsible for regulating the plan. The experience gained in the operation of appeal procedures under workers' compensation will provide a very useful starting point.

52. The Committee recommends that any comprehensive disability financial protection plan provides an appropriate appeal mechanism so that once a judgmental decision is made under the plan, the disabled person would have the right to go somewhere else to have his or her case heard if he or she is not satisfied.

The Canada Pension Plan and Unemployment Insurance and a Comprehensive Disability Financial Protection Scheme

53. The Committee recommends that a comprehensive disability financial protection plan anticipate the dropping of income protection provisions during periods of disability from both the Unemployment Insurance and Canada Pension Plan programs.

The Unemployment Insurance plan would then operate as it was originally intended as a plan to protect income during periods of unemployment and the Canada Pension Plan would operate as a plan designed to provide a basic level of pensions to contributors to the plan when they retire.

The "Pay-as-You-Go" Concept

The Committee does not view a comprehensive disability financial protection plan as a form of insurance. Therefore, it rejects the concept of attempting to establish premiums and related sources of revenue on a basis designed to accumulate funds sufficient to compensate those becoming disabled in any one year for as long as they require assistance.

54. The Committee recommends that a comprehensive disability financial protection plan be based on the concept of pay-as-you-go with revenues in any one year designed to match the necessary expenditures in that year anticipating neither a "profit" nor a "loss" on the operations of any one year.

CHAPTER 25

Disability Income Protection — Improving the Present System

A. INTRODUCTION

The Committee has indicated in earlier chapters of this Part that it agrees in principle with the introduction of a comprehensive integrated system of disability financial protection for the residents of Ontario. It has also indicated that it realizes that this is not possible immediately and explained that, nevertheless, it is loath to patch the present system and indeed does not believe that any patching can be done well. The Committee believes that this is particularly true in the area of income protection for residents during periods of disability.

It was for this reason that in Chapter 24, the Committee gave some consideration to certain of the principles and concepts that it believes should be reflected in a comprehensive, integrated disability financial protection plan for Ontarians with particular emphasis on the income protection elements of such a system. In considering these principles and concepts, it has been the main objective of the Committee to point a direction for such a system. The detailed consideration of such a system is beyond the present mandate and ability of the Committee and it therefore has suggested that an interministerial committee be organized as soon as practical to give detailed consideration to the design of such a plan, its costs measured against the savings in the present piece-meal system, its funding, its administration and so on.

The Committee recognizes that it will take some time to complete the task of designing and implementing a comprehensive disability financial protection plan for the residents of Ontario. Therefore, in spite of its reluctance to tinker with the present system, it is prepared in this chapter to make suggestions aimed to smooth out some of the problems and gaps of the present system and as a minimum improve the system as it presently exists. It will be apparent as these suggestions are reviewed that they are designed to take a halting first step towards accomplishing the principles and concepts outlined in the previous chapter for a co-ordinated universal disability income protection plan for all residents of the Province.

B. IMPROVING THE PRESENT SYSTEM

In the first two Parts of this Report, the Committee reviewed the array of public and private sector disability financial protection plans available in Ontario. As it did so the Committee became frustratingly aware of the gaps, inconsistencies and anomalies in these plans as they affect the various levels of society making up the residents of Ontario.

For purposes of illustration the Committee has prepared the table on the following two pages, dealing with the income protection elements of many of these plans under a number of headings. Data in this table have been prepared from the perspective of the individual and segregated to show—government plans, federal and provincial, and private plans available to employees; other government plans, federal, provincial and municipal; and other private plans. Each plan has been reviewed from the point of view of availability; eligibility; waiting period for benefits; level of benefits; duration/termination of benefits; direct contributions by the person covered; and, whether the benefits are subject to income tax. Information in the table for the plans shown is as of December, 1980. The table is not meant to be a complete summary of all of the alternative income protection options open to individuals during disability but is illustrative of the complexity of the present unco-ordinated, fragmented “system”.

The Committee’s suggestions for improving the present system are set out below under a number of headings dealing with various aspects of income protection. The Committee’s views on improving the present system of rehabilitation of the disabled in Ontario are outlined in the next chapter.

Improving Disability Income Protection Coverage

In its concept of a comprehensive disability financial protection system, the Committee had made it clear that it believes that all residents of the Province should be covered—workers, farmers, the self-employed, those with congenital defects, non-earners and so on. The Committee then went on to acknowledge that it may be necessary to introduce its concept of a comprehensive plan in stages possibly as some have done by making the plan applicable to all those disabled by way of accidents first and later expanding the plan to include all those disabled as a result of disease or sickness.

The Committee suggests an alternative for immediate consideration by the appropriate Ministers of the Government and the Assembly that of introducing a comprehensive plan that would include all those disabled as a result of congenital defects. It seems to the Committee that this would be a very logical place to start particularly in this the “International Year of the Disabled Person”. From this base it might be feasible to extend disability income protection in stages to other groups for example, farmers or the self-employed. More detailed analyses might indicate the practicality of incorporating smaller groups into the scheme in relatively rapid succession as a feasible mechanism for the efficient introduction of a comprehensive disability income protection plan to cover all residents eventually.

Periodic Payments

In general, the various government plans providing income protection to the disabled make benefit payments to recipients on a periodic basis rather

OVERVIEW OF INCOME PROTECTION
(excluding death provisions (if any))

TYPICAL COVERAGE FOR A SINGLE PERSON

PLAN OR SCHEME

	<u>Availability</u>	<u>Eligibility</u>	<u>Waiting Period</u> Initial Benefits Become Payable	<u>Level of</u> <u>Benefits (1)</u>	<u>Duration/Termination</u> <u>of Benefits</u>	<u>Direct Contributions</u> <u>by Persons Covered</u>	<u>Benefits Subject</u> <u>to Income Tax</u>
A. FOR EMPLOYEES (from the employee's perspective)							
1. GOVERNMENT PLANS							
1.1 Federal Government							
Canada Pension Plan	available to workers under age 65 who contributed	for "disabled" employees who have contributed for at least 10 years; definition of disability is strict	4 months	a flat amount plus a share of the retirement pension monthly, maximum \$160.38 per month	recovery, age 65 or death	shared with employer	yes
Unemployment Insurance	available to employees under age 65 working 20 or more hours per week	for employees who contributed for at least 20 weeks in the last 52	2 weeks	60% of insurable earnings to a maximum of \$754 monthly	15 weeks or upon re-employment	shared with employer	yes
1.2 Provincial Government							
Workers' Compensation (2)	available to employees in specified industries	for all such employees except when wilful misconduct is involved	none	75% of earnings, with a maximum payment of \$15,875 yearly	Board assesses extent of disability. Payment can be a lump sum or can continue until completion of a specified rehabilitation program, or for life	none	no
No-Fault Automobile Accident Benefits	available to residents involved in traffic accidents in Ontario	actively engaged in occupation or employment for at least 6 of the 12 months preceding the accident; disability must occur within 90 days of the accident; definition of disability is strict	none	80% of gross income to a maximum of \$407/week integrated with other plans	80 weeks, after which a permanent disability must be proven	none	no
2. PRIVATE PLANS							
Voluntary Payments by Employers	only available from some employers	for full time employees meeting service qualifications	none	up to 100% of regular pay	until another income protection plan comes into force, or the stipulated end of benefit period	none	yes
Sick Leave Plans	only available from some employers	for full time employees meeting service qualifications	none	up to 80% of regular pay	same as voluntary payments by employers	none	yes
Weekly Indemnity Plans, Insured (3)	available from many employers	for full time employees, after a probationary period, and actively at work	accidents, none sickness, 4 to 8 days	flat weekly amount, or % of regular wages, typically 6% to 100%	until a long term income protection plan comes into force or the end of a stipulated benefit period	usually shared with employer	yes, if any part of contribution is by employer
Notes: (1) - Benefit levels indicated in this table are those in effect as at December 1980. Some benefits are reduced when other benefits are received from other plans or schemes. (2) - Workers' Compensation only covers occupational accident or illness. (3) - Weekly Indemnity usually covers non-occupational accident or illness.							

**OVERVIEW OF INCOME PROTECTION
(excluding death provisions (if any))**

PLAN OR SCHEME	TYPICAL COVERAGE FOR A SINGLE PERSON						
	<u>Availability</u>	<u>Eligibility</u>	<u>Waiting Period Until Benefits Become Payable</u>	<u>Level of Benefits (1)</u>	<u>Duration/Termination of Benefits</u>	<u>Direct Contributions by Person Covered</u>	<u>Benefits Subject to Income Tax</u>
Other Pension Plans	only available from some employers, not usually portable	for "disabled" employees having suitable age or years of service, strict definition of disability	varies, usually tied in with long term insured plans	a flat amount monthly	for life	usually shared with employer	yes, if any part of the contribution is by employer
Long Term Income Continuation Plans, Insured	available from many employers	for full-time employees, after a probationary period, actively at work	designed to integrate with public and private plans	% of earnings, typically 65% to 75% of take-home pay	recovery, stated period (2 to 5 years), age 65, or death	usually shared with employer	yes, if any part of the contribution is by employer
Group Life Insurance Disability Provisions	only available from some employer's group life plans	for "disabled" employees who have met service qualifications and were actively at work, strict definition of disability	varies, satisfactory proof of disability must be provided	varies with face amount of policy	usually 5 years	usually shared with employer	no
B. FOR INDIVIDUALS (from the individual's perspective)							
1. GOVERNMENT PLANS							
1.1 Federal Government							
Veterans' Disability Pensions	Canadian veterans	disability or aggravation of a pre-service disability attributable to specified military and sometimes civilian service	none	based upon assessment of % of disability, indexed to C.P.I.	benefits are for life regardless of employment or other pension plans	none	no
1.2 Provincial Government							
Family Benefits	residents of Ontario	applicants must undergo a needs test	from initial application to qualification for benefits can take up to six months	standard level of income for persons in need	as long as eligibility requirements are met or until another government plan takes over	none	no
1.3 Municipal Governments							
General Welfare Assistance	residents of a municipality	applicants must undergo a needs test	none	designed to cover basic living needs	short term until family benefits take over or until no longer meet eligibility requirements	none	no
2. PRIVATE PLANS							
Programs for Individuals, Insured	limited availability and tight underwriting	definition of disability is strict	varies, period for short term coverage is usually longer than employer plans, long term coverage often commences when short term coverage terminates	flexible to meet individual's needs, long term coverage is typically 65% to 75% of take-home pay	short term coverage up to 6 months for sickness and 12 months for accident, long term coverage for a stated period (2 to 5 years) or until recovery, age 65, or death	all	no, unless funded by individual's business
Programs for Individuals Who are Members of Groups, Insured	available for some group or association members	definition of disability is strict	varies, period for short term coverage is usually longer than employer plans, long term coverage often commences when short term coverage terminates	flexible to meet individual's needs, long term coverage is typically 65% to 75% of take-home pay	short term coverage up to 6 months for sickness and 12 months for accident, long term coverage for a stated period (2 to 5 years) or until recovery, age 65, or death	all	no, unless funded by individual's business

than in a lump-sum. The concept of periodic payments by the private sector in settling claims is less well accepted and in circumstances where a lump-sum payment may be one alternative, the Committee gained the impression that the insurance industry, simply on the basis of administrative simplicity would frequently encourage beneficiaries under insured plans to accept a lump-sum payment in full settlement.

The Committee reiterates its view expressed earlier that the only suitable means of providing income protection to the disabled is by way of periodic payments, not by way of lump-sum settlements. The only justification for lump-sum settlements in a comprehensive disability financial protection scheme would be to provide modest lump-sum payments for pain and suffering and loss of amenities.

Level of Benefits

A continuing thrust in improving disability income protection in Ontario in order to eliminate some of the gaps, inequities and anomalies in the present system must be to provide more generous levels of benefits. In the Committee's view it is not adequate merely to provide a basic or sustenance level of benefits. The anomalies in the present government plans should be a first area of review by an interministerial committee. Essentially the Committee is of the view that disability income protection should be provided to earners at 85-90% of normal earnings with a high maximum.

The Committee has suggested earlier in this chapter that extension of disability income protection might begin immediately with improved benefits to those disabled as a result of congenital defects. In regard to the level of benefits to be paid to approved claimants, the level should be sufficient to permit those in receipt of benefits to maintain their self-respect, pride and personal esteem and not merely sufficient for them "to get by".

Indexing of Benefits

The recipients of disability income benefits under any government sponsored plan in Ontario should have their benefits indexed in an appropriate manner so as to preserve the purchasing power of their benefits. While the Committee has expressed its concern about "institutionalizing inflation" with indexing of benefits, it cannot in conscience justify permitting the disabled, of all people, to have their standard of living deteriorate because of inflation. The Committee does not necessarily believe that the cost of living index is an appropriate index to be used for adjusting benefits to the disabled and suggests rather that the average industrial wage index or some other index or combination of indices might be more appropriate.

The Committee is aware that the private sector may have established its premiums for disability income protection to insureds without appropriate

provision for the rapid increase in inflation in recent years. As a consequence, insurers have indicated they are unable to index the benefit payments they make. The Committee would only observe that in establishing their premiums insurers were, as well as being unable to forecast the high levels of inflation, unable to forecast the high levels of interest rates in recent years.

55. The Committee encourages the insurance industry to reassess their policy with regard to indexing of income benefits particularly for those suffering long-term disability whose income and standard of living may have deteriorated as a result of inflation and who are without recourse.

Funeral Expenses

Many of the public and private sector disability income protection plans provide for a lump-sum payment in the event of death to defer a portion of funeral expenses. It has been brought to the attention of the Committee that the level of these payments is rarely adjusted and that in general under most plans payments are inadequate considering the cost of most funerals today.

56. The Committee recommends the level of funeral benefits paid under both government and private plans be reviewed on a regular basis so that they may be kept more closely in step with the costs of a basic funeral.

Definition of Disability

The Committee was struck with the inconsistency in the definition of disability among the various government plans and among plans provided by insurance companies.

The Committee acknowledges the problems involved in defining disability. However, from the perspective of the consumer the lack of a consistent definition of disability and therefore a basis for determining how long benefits will be paid and when they will be terminated is an area of confusion, concern and frustration. It would seem to the Committee that one of the items of highest priority for the Assembly in connection with improving the present disability income protection in Ontario is to see reflected in legislation consistent definitions of disability to be applied equitably to those entitled to benefits under various government plans.

57. The Committee recommends that an appropriate interministerial committee be instructed to review the various definitions of disability in legislation and their application in practice and report to the Assembly through the Minister of Labour during the next session of the House.

Statutory Condition 4

Both the Superintendent of Insurance for the Province and the insurance industry recommended that Statutory Condition 4, reference sections 249 and 250 of The Insurance Act be eliminated from The Insurance Act to permit the integration of individual policy benefits not only with those provided by other insurance policies but also with those available under public programs. In appearances before the Committee, both the Superintendent and CASSI outlined the problems created by Statutory Condition 4 and its relation to the problem of over-insurance. Reference to these presentations and submissions is contained in Chapter 12, Section F.

58. The Committee recommends that Statutory Condition 4, reference sections 249 and 250 of The Insurance Act be eliminated from The Insurance Act with the aim of reducing over-insurance on the part of individuals.

At present claimants will have some or all of their premiums returned to them for any over-insurance they may have at the time of their claim. However, the vast majority of policyholders never make a claim against their disability income protection coverage and as a consequence may pay premiums for a long period of time for coverage that is of no value to them.

59. In recommending the elimination of Statutory Condition 4, the Committee supports the view expressed by the Superintendent of Insurance during its hearings and recommends further that he oversee the insurance industry as it makes the necessary adjustments in premiums, possibly including any refund of premiums, to policyholders and in general the orderly transition that will be involved in this change.

Group Life Insurance—Disability Provisions

In the Committee's Fourth Report on Life Insurance, it noted on page 188 a number of matters concerning disability provisions contained in some group policies to quote

“ . . . two main types of disability provisions are currently offered in group life insurance contracts; a waiver of premium provision and a disability instalment provision. . . . the waiver of premium provision . . . provides that, in the case an employee becomes totally disabled, future premiums under the group contract will be waived by the insurance company.

The disability instalment provision, although it is not offered in all group contracts, is available for an extra premium. It provides that in case an employee is totally or permanently disabled, the amount of insurance benefits under the policy will be paid in regular instalments over a period of years, usually 5. This provides the disabled person

with the benefit of income payments out of his group life policy. The instalment payments, however, reduce the amount of insurance in force and at the end of the payment period, the life insurance contract is terminated. Termination of coverage through payment of the sum insured may provide needed disability benefits to the disabled employee but it results in loss of life insurance coverage at the time when ordinary life insurance may be difficult to obtain.

The terms of the disability instalment provision in effect alter the life insurance contract to a contract of disability benefits. In some cases, the disabled employee may not regard this position of his life insurance coverage to be most appropriate to his circumstances but no other options are made available to him with this provision in force.”

The Committee therefore recommended:

- 6.3 The Committee emphasizes that the primary purpose of regulations pertaining to group life insurance coverage should be to provide group insured lives with the assurance of continuity of coverage, particularly with respect to situations of termination of group coverage and with respect to persons who are disabled while covered by a contract of group insurance, even if that contract is terminated at some later date. In regard to the latter point, the Committee recommends that The Insurance Act be amended to make it mandatory that all group contracts provide waiver of premium coverage in the event of disability.

However, the Committee in its previous report did not make any specific recommendation concerning the second of the above situations. As it reviews this matter today the Committee has no objection to providing for the payment of life insurance benefits under a group life policy in the form of disability instalments. However, as a minimum—

60. The Committee recommends that beneficiaries be given the option to accept the disability income provision of group life policies or to leave their group life insurance intact as opposed to being denied this latter alternative as at present. The Committee reiterates that there should be a comprehensive disability financial protection plan for all residents of Ontario providing a level of benefits adequate to sustain the standard of living at a high maximum level. Acceptance of this concept is incompatible with the need for the disabled to use their life insurance coverage to maintain income during periods of disability.

CHAPTER 26

Rehabilitation and the Duration And Termination of Disability Income Protection

A. INTRODUCTION

In Chapter 24, the Committee discussed its views of some aspects of a comprehensive disability financial protection system which should be the aim for Ontario. Included were brief comments on matters concerning rehabilitation of the disabled and the duration and termination of income protection to the disabled. In this chapter, the Committee will expand on these concepts as they relate to rehabilitation and suggest the direction for improvements in the present system in Ontario. The Committee *believes* that of all the issues related to the subject of a disability financial protection system, the matter of rehabilitation is the most pressing and deserving of the immediate attention of all, whether in government, in public institutions, in professional practice, in industry, in the business of insurance or in any other capacity, who are in a position to improve this vital area of concern to the disabled.

In an earlier portion of this Report, the present rehabilitation services available to the sick and disabled in Ontario and certain related matters were discussed under a number of headings—eligible workers; eligible veterans; insured persons; other programs for children, adults and the co-ordination of government programs; and, employment after sickness or accident. It is readily apparent that rehabilitation programs for disabled residents of Ontario are fragmented, inconsistent and unco-ordinated. In this regard, the comments contained in a report “A Hit-and-Miss Affair” prepared by the Canadian Council on Social Development in the mid-1970’s discuss the unco-ordinated rehabilitation programs in the country and asked “Should there be four systems?” Portions of the comments in the section of that report dealing with this question follow:

“The medical rehabilitation system has been coming under a good deal of scrutiny over the past few years. In part this has arisen during examination of the whole health care system and its increasingly high costs. In this process it could hardly fail to be noted that an efficient medical rehabilitation system that reduces pressure on acute care and extended care beds would make an excellent investment.

Once the medical rehabilitation system itself begins to be examined, then one of the matters bound to be raised is the use of existing resources and the rationality of running a number of parallel systems. One of these, the Veterans’ System, is itself taking steps to integrate its resources with the general provincial system by progressively handing over its hospitals to the provinces. The existence of separate workers’ compensation facilities is also being questioned. The

Working Party in Physical Medicine and Rehabilitation, for example, quoted the existence of separate workers' compensation board centres as an example of "wasteful duplication" of rehabilitation services that should in future be avoided.

There are already a number of provinces and territories that do not have separate workers' compensation facilities. With the exception of New Brunswick (which does), these are the provinces and territories of a million or less population size. None of these appears to have any intention of developing a separate WCB service. Rather, they are concerned with upgrading the medical rehabilitation facilities for the population at large."

"Some rather tentative thinking about the need for a more integrated system is to be found in the four provinces that have well established WCB facilities. Ontario has concentrated first on reorganizing its adult system and to an extent its Children's Systems. Its Council of Health was set to work on studying rehabilitation services in 1970. The report, which contained 47 recommendations, was directed to the regionalization of rehabilitation facilities and to various means of ensuring access to the services and their efficient operation. Although the report was never officially adopted, many of its recommendations have been or are in the process of being carried out. This has included the establishment of regional rehabilitation centres in London, Hamilton, Kingston, Sudbury, Thunder Bay and Ottawa. So far there appear to be no formal moves to take over the WCB facility, though the question was raised by the Ontario Task Force on the Administration of Workmen's Compensation in Ontario. Its 1973 report commented on the board's Downsview centre:

The Hospital and Rehabilitation Centre offers superb facilities. This fact suggests a number of questions: can these facilities be utilized more effectively if treatment was extended to the general population, can the WCB make increased use of other facilities in the Province to avoid bringing people in Toronto, should the program continue to be delivered by the WCB or within the general health care delivery program of the Province?"

"There is rather less attention being paid to the existence of separate children's systems, perhaps because these are easier to justify in relation to the special needs of young children. However, it was evident at the project meetings that two important concerns created the need to examine how resources are allocated and how the system as a whole functions. These were the problems of providing for children living outside the major centres (particularly those in remote areas) and the serious difficulties experienced when a child outgrew the Children's System but still had many needs not adequately met in the adult (general) system.

It is reasonable to expect that the desirability of making rational use of all available resources through an integrated rehabilitation system will be discussed each time the need for an improved system of medical rehabilitation is examined. However, this does not necessarily mean that drastic change will occur. Reorganization is not an easy process where heavy commitments have been made to a particular kind of system, and it may well be found that the political will to provoke hostility will be lacking, however rational change may seem."

B. GENERAL IMPRESSIONS AND CONSIDERATION REGARDING THE PRESENT SYSTEM OF REHABILITATION IN ONTARIO

In the first place the aims of rehabilitation are medical. They are designed to speed the healing process, to eliminate physical disability, if possible, to reduce or alleviate the disability to the greatest extent possible, and to prevent regression or further disability. The second aims of rehabilitation programs are more vocational in nature with the purpose of assisting patients to maintain their present abilities and functions; to retrain in their old activities, or train in new activities; to train or retrain those with residual disability to live and work within the limits of their disability but to the extent of their capabilities; to restore a worker to employment, where possible, in order to minimize compensation and disability payments; and, to achieve a satisfactory level of physical, cultural, social and recreational activities.

In the Committee's view, in Ontario, we pay positive lip service to rehabilitation but do not really deal with it.

The system, such as it is in Ontario, responds to the rehabilitation needs of the disabled differently for various qualifying people—workers injured at work; veterans; and children. There are glaring gaps, inconsistencies and anomalies in the rehabilitation of the disabled usually dependent upon the cause of the disability rather than its nature. As discussed more fully later in this chapter, the Workmen's Compensation Board rehabilitation program, is not available to other than injured workers and is not making services equally available to all workers mainly because of the problems of the geography of the Province.

It is generally conceded that the worker's compensation rehabilitation program is the most advanced in the Province. Some even suggest that it be used as a model for the rehabilitation of those disabled other than at work. The Committee is *prepared to admit* that the rehabilitation program of the Workmen's Compensation Board is the best available in Ontario. The Board has excellent facilities and in general it does a very good job of the medical aspects of rehabilitation. However, that is as far as it goes. In the *Committee's view*, it does an inadequate job of educational and vocational rehabilitation; does a poor job of many aspects of the re-employment of the disabled; and has

a dismal record when it comes to matters relating to the psychological rehabilitation of the disabled.

In the *Committee's view*, the rehabilitation program of the Workmen's Compensation Board as it relates to the rehabilitation of injured workers cannot be accepted as a model for the rehabilitation of all disabled in the Province.

Duration and Termination of Disability Income Benefits

Many of the Committee members consider the major problem, both in the present and any proposed system, of financial protection for the disabled as being the determination of the duration and termination of disability income benefits. The question is who makes and on what basis is the decision made that a person continues or ceases to be disabled. Briefly stated the basic issue was summarized extremely well by the Woodhouse Committee in its report on the proposed comprehensive system for Australia, as follows:

"The primary object of the scheme must be to encourage every incapacitated person to recover the maximum degree of bodily health and vocational utility and social well-being at the earliest possible time. That objective must never be impeded. On the contrary, every incentive must be built into the system for the promotion of personal effort, individual reliance and final self-respect. Through rehabilitation, the scheme will provide the incentive to get well. It will offer the real incentive that is given to people who know their entitlement to assistance will be thoroughly measured against this real need. By offering compensation at 85% of past earnings, it will replace almost all the whole of a person's losses without the over compensation that would arise if earnings were replaced in full and without some appropriate deduction for the travelling and other expenses of the working week that had been saved. At the same time if the scheme is to receive the public support it requires and deserves, it must not be involved in misplaced gestures of easy and unneeded help for every minor ache and pain."

The basic issue of rehabilitation is to get the disabled back to where they were and to provide every incentive for them to do so.

A disability protection system is incomplete without prompt, effective rehabilitation of the sick, injured and disabled. In his report "Canada's National-Provincial Health Program for the 1980's," Justice Hall included the following reference on page 66:

"Dr. Gustave Gingras, CC, Director, Rehabilitation Services, Ministry of Health, Prince Edward Island, an outstanding authority on rehabilitation said:

"Rehabilitation can no longer be based on a purely humanitarian basis. If it were, it would become too great an opportunity for the

bio-psychologist! Rehabilitation cannot and, indeed should not, be devoid of humanitarian background but, let us admit, that it is now a well-established science. The word "science" is possibly ill chosen here. Let he compromise for a more panoramic term such as philosophy or doctrine."

"The concept of total medical care must and should include rehabilitation as its ultimate goal. Whenever full restoration is denied, considerable recuperation can still be gained via the ministrations of rehabilitation medicine and psycho-social techniques."

It is important to *reiterate* the importance of co-ordinating medical care to speed the healing process with vocational related rehabilitation to include—occupation, recreation, and other rehabilitation needs and facilities for the disabled.

C. IMPROVING THE WORKMEN'S COMPENSATION BOARD'S REHABILITATION PROGRAM

It has been noted the Committee believes that, in general, the Workmen's Compensation Board has developed a satisfactory rehabilitation program as it relates to the medical care of the disabled worker. However, it is important that the Board not stop there. It must follow through from the physical rehabilitation of the injured worker to other aspects of rehabilitation to ensure that rehabilitation is complete and the disabled are able to take their place in society with self-respect.

The Workmen's Compensation Board is in a unique position. From the point of view of the work of this Committee and its recommendations regarding extending a comprehensive plan beyond workers to other areas, it has to look at the Workmen's Compensation Board as the only existing agency in Ontario which has a responsibility from the date of an accident or industrial related illness to the return of that person to the work force or if he or she cannot return, provide for his or her protection for the rest of life. The Board has the only rehabilitation program in Ontario for the Committee to look at. While there are positive things to say about the Board and its rehabilitation programs, the Committee must observe on its shortcomings and what more is expected.

61. The Committee reiterates its concern regarding the inadequate vocational rehabilitation and psychiatric assistance provided to the disabled by the Workmen's Compensation Board and recommends to the Board that more attention be devoted to these important areas of rehabilitating disabled workers.

Essentially, in the Committee's view, few really understand the complexity of and expenses involved in total rehabilitation and indeed it is possible that no one has attempted to assess the full complexity of the issue.

Estimates have been made that for a middle class resident of Ontario the costs involved of a comprehensive rehabilitation program would be a minimum of \$15,000 and likely considerably more. No individual expects to bear such a cost burden. Viewed in the context of rehabilitation of disabled workers, the Board doubtless has a serious problem in the allocation of dollars to vocational training. The multi-cultural background and problems of language of disabled workers compound the Board's problems of both vocational and psychological rehabilitation.

The new Chairman of the Workmen's Compensation Board, the Hon. Lincoln Alexander, PC, QC, indicated to the Committee members that he shared their concerns and that he proposed to direct more of the Board's attention to matters relating to vocational and psychological rehabilitation and in general to rehabilitate disabled workers back to the point where they were before they sustained their injuries.

The Committee is encouraged by the statements made by the Chairman of the Workmen's Compensation Board and urges him to follow through and in general expand the mandate of the Board beyond its prime concern with physical rehabilitation into a more comprehensive and thorough rehabilitation program. The Workmen's Compensation Board has never been subject to a close scrutiny in the detail that the Committee visualizes is necessary to reassess its mandate.

62. The Committee recommends that the Chairman of the Workmen's Compensation Board carry out a searching scrutiny as he considers the Board's future and reassess its mandate along the lines he discussed before the Committee, and that the review keep in mind the importance of considering all aspects of rehabilitation of the disabled and the expense involved, so that the information will be of value not only to the Board in dealing with injured workers but to others concerned with the rehabilitation of those disabled by other than by work-related injury or disease.

D. TRAINING OF QUALIFIED REHABILITATION PERSONNEL

One of the more distressing aspects of the rehabilitation of the disabled in Ontario is the lack of a core of people trained or being trained to help the disabled with their psychological problems. Further, there are no training courses either at the university level or otherwise for workers in the field of social and economic rehabilitation. This situation is inexcusable particularly when it is realized that Canada has the highest percentage of institutionalized disabled and handicapped citizens in the world. Changes are essential to improve the rehabilitation of the disabled.

At a recent rehabilitation conference at the University of Western Ontario, Dr. Martin Hollenberg, Dean of Medicine of the University of

Western Ontario commenting on the sad deficiency in the areas of research and education in rehabilitation stated—

“There is a need for a high quality centre for the training of students in rehabilitation, which cannot be accomplished only in lecture halls and laboratories”.

Dr. Hollenberg went on to say there is a real shortage of trained workers in rehabilitation—from doctors to nurses, therapists, teachers and home-care workers.

At that same conference, Dr. Gustave Gingras, Director of Rehabilitation Services for the Department of Health of Prince Edward Island, said

“Persons hired to work in rehabilitation centres should have a vocational inclination and he found it unacceptable that schools of nursing do not teach rehabilitation medicine”.

The Committee concurs and

63. The Committee recommends that the Ministry of Education and the Ministry of Health undertake immediately studies and initiate programs to establish training courses in appropriate educational and other facilities designed to ensure that personnel will be available to assist the disabled in matters relating to their vocational, social, economic and psychological rehabilitation.

On the subject of rehabilitation of the disabled, the Committee is pleased that the Minister of Education introduced and the Assembly passed Bill 82, an act to ensure that every exceptional pupil in the Province of Ontario receives an education suited to his or her needs and abilities. Bill 82 ensures:

- universal access of all Ontario school-aged pupils to a publically supported education, regardless of the pupils’ special needs;
- the provision of special education programs and special education services that meet the needs of exceptional pupils; and
- involvement and participation of the parents or guardians of exceptional pupils in the assessment, identification and placement of such pupils, including the right to withhold permission for a particular placement and the right to require a review of the pupil’s placement at any time.

E. FACILITIES FOR REHABILITATION

It has been noted that there are a great many government and voluntary groups involved in providing rehabilitation services to various segments of the disabled requiring assistance in Ontario. There will likely always be problems associated with coordinating these programs since they involve such a vast spectrum of disabled whose needs vary because of the nature of their disability, their age and so forth.

In the Committee's view, there is significant opportunity for better co-ordination of these programs through the better utilization of existing facilities. There are all kinds of facilities across the Province organized on regional bases—hospitals, colleges and universities which should allow a great deal more to be done in rehabilitating the disabled. It would seem to the Committee that the opportunities to improve vocational rehabilitation on a regional basis would be a particular area where improvements could be expected. Research on vocational training might be an appropriate area in which regional universities could participate.

64. The Committee recommends that an inventory of rehabilitation resources be prepared for the Province as a whole and for the various regions of the Province. With such an inventory, a focus can be provided for voluntary groups on a regional basis. Better utilization of the facilities and co-ordination of the efforts of all groups could be expected to be of almost immediate benefit to the disabled.

The emphasis should be on cooperation in co-ordinating the use of resources. The available resources should be well used, not duplicated. In this way, better use of the available funds for rehabilitation projects can be assured even within the constraints of the present system and current economic conditions.

F. REHABILITATION OF THE DISABLED WORKER

As part of its rehabilitation program for disabled workers, the Workmen's Compensation Board has set up employment offices to assist in re-establishing those persons in the work force. While recognizing that such steps are necessary, the Committee questions whether this is an appropriate role for the Workmen's Compensation Board or at least whether this matter does not require more stringent government intervention than the Workmen's Compensation Board is able to exert.

The Committee has in mind situations where the WCB might find a job of light work for a rehabilitated person with wages supplemented by the Board, but when the supplement runs out the person is laid off or fired. The very basic question arises as to whether the problem should be left to the initiative of the employers who hire rehabilitated persons for light work or whether, for example, employers should be required to have quotas of injured or disabled workers on their payrolls. Many countries such as Great Britain, Japan, West Germany, France and Italy have a system of mandatory quotas of disabled persons that designated employers must employ. There is no such plan in operation in Canada. The Committee believes there should be—

65. The Committee recommends that the Minister of Labour introduce legislation requiring designated employers in the Province to employ a mandatory quota of disabled persons.

The Committee is somewhat reluctant to comment further on the rehabilitation of disabled workers in view of the ongoing study of this and

related matters being conducted by Professor Paul Weiler, who is dealing with this subject in much more detail than this Committee is able. However, the Committee feels that it must make two related observations and recommendations.

There appears to be a common misunderstanding regarding the disabled that in part explains the reason for the high unemployment rate for the disabled. Some of these misunderstandings are:

- insurance rates will increase dramatically;
- modifications to the work site will entail considerable expense;
- safety records will be poor;
- productivity will decline; and
- other employees will not accept the disabled.

To the contrary studies have shown that disabled workers are equal to and sometimes better than other employees; they are eager to work; and frequently cut down on absenteeism.

66. The Committee recommends that the Workmen's Compensation Board encourage companies to take disabled persons back on their payroll by perhaps offering them an adjustment of their workers' compensation rating.

Further,

67. The Committee recommends that matters of persons displaced because of disability be dealt with under the auspices of the Department of Manpower who likely have more specific expertise relating to displaced persons and their re-employment than does the Workmen's Compensation Board.

The Committee is pleased to note that the Handicap Employment Program of the Ontario Ministry of Labour has a mandate to work with employers, trade unions, handicapped individuals and groups, local agencies, insurers, professionals and government programs to encourage the recruitment, retention and promotion of handicapped individuals in private sector employment. In this regard the Ministry has prepared a Fact Book explaining that previously the handicapped were thought of as those with visible disabilities: the blind, people in wheelchairs, victims of accidents, and those with congenital defects or degenerative disease. Now it is generally accepted that a much broader definition is more appropriate, encompassing all conditions that prevent individuals from functioning normally in society.

People with mental and emotional illnesses as well as those whose handicaps are "hidden" are now recognized as handicapped. "Hidden" handicaps include such things as the physical limitations resulting from heart or circulatory disease, epilepsy, cancer and alcohol or drug abuse.

According to the Fact Book, ensuring fair and equal opportunities for the handicapped involves adopting what might be called "positive employment

practices'' which may range from modifying existing personnel practices all the way up to developing special employment programs.

Much more is required. At present in Ontario, the Human Rights Code only provides that an individual's race, religion, nationality, age or sex must not be a determining factor in hiring or firing, or in treatment in employment. Nowhere in the Code is a specific protection provided for the disabled. In the Committee's view an appropriate amendment to the Code is overdue.

68. The Committee recommends that appropriate amendments be made to the Human Rights Code to ensure that an individual's disability will not be a determining factor in hiring or firing, or in treatment in employment.

G. TERMINATION OF INCOME PROTECTION BENEFITS

The Committee is very concerned that the operative concept underlying the duration and termination of income protection benefits to the disabled is more dependent upon the number of months of benefit payments than on whether the recipient has been rehabilitated. In effect, someone says to a disabled person "you are finished". In the Committee's experience this is the source of the largest number of serious complaints concerning the operation of the Workmen's Compensation Board. Typically a disabled worker is told he or she does not meet certain qualifications; for example, attending rehabilitation meetings or trying for a job.

The basic problem to individuals stricken by accident or sickness and expecting to return to work is that they receive medical care and then it is a question of either rehabilitation or income protection for a short period or a longer period. There is no denying there are very real problems in training and re-training: training for one job, failing at it; training for another job, failing at it and re-training again. Who stops rehabilitation and says "this is the end of the road"? Sometimes this is done by stipulating a period of time. Under any scheme there will always come a time when someone has to say a person is no longer sick or disabled and is now rehabilitated.

All who are concerned with the problem recognize that there is a need for a mechanism to establish the degree of disability that people can understand and thus appreciate the way the system works. In the Committee's view the present system frequently operates against the injured worker. The example is used that the Ombudsman recently accepted 106 appeals based on the fact that the assessment of partial disability of injured workers was based only on the clinical aspect of the injury and no other aspects of the workers' disabilities were taken into account. The Ombudsman concluded in every case that these other aspects should have been considered when evaluating the injured worker and assessing disability.

Professor Weiler has recognized this problem and proposes to deal with the matter by establishing a Board of Doctors to assess partial disability and

when the disabled are rehabilitated. Professor Weiler is only part way through his study and will likely have more to say on the operations of such a Board in his second report due next year.

The review board concept was also suggested by the Woodhouse Committee in proposing a comprehensive system for Australia wherein it was recommended that a Board of Evaluation be appointed to determine the extent of partial disability and when the disabled were rehabilitated.

As the Committee views the present situation regarding termination of benefits to the disabled in Ontario, it does not have the capacity to come up with the answer as to how a decision should be reached that benefits should be terminated. It does recognize that somehow someone is going to have to be put in a position to say no. The Committee can only help to illustrate the dimensions of the problem. In that context *the Committee notes*:

- In Ontario we are still inclined to use Napoleonic surgical schedules to determine disability; whereas the real problem is what is the functional disability that a person suffers.
- In the relatively recent past there are two areas of medical treatment that have become almost totally discarded as they related to the disabled: the cutting off of compensation because a person refused to take electric shock treatment; and, benefits being cut off because a person would not take surgical treatment for a back injury.
- Regarding rehabilitation in the sense of retraining and giving a person another vocational course, in the Committee's view each person has to be looked at in a personal sense.

Over the years the Workmen's Compensation Board has encountered most of the problems that will continue to haunt any comprehensive disability financial protection scheme as it relates to rehabilitation. Similar problems are bound to arise as rehabilitation programs are extended beyond the eligible workers under workers' compensation.

H. REHABILITATION AND THE INSURANCE INDUSTRY

Few of the witnesses that appeared before the Committee representing insurers or the non-profit prepaid medical care organizations mentioned rehabilitation unless prompted by the Committee. It is evident that rehabilitation programs by insurers are not looked upon by any of them as matters of high priority. While some companies have established staff to assist in the rehabilitation of injured insureds, others created the impression that they view rehabilitation as a cost containment aspect of claims settlement, still others appear not to do anything about rehabilitation.

The Committee commends CAASI on the organization of their special rehabilitation Committee to which reference was made in Chapter 16 of this Report. The Committee notes however the entirely voluntary nature of the rehabilitation work carried out by insurers and as a consequence many

insureds who would benefit from a rehabilitation program do not have such programs made available to them.

It also became clear during the Committee's hearings that little effort has been made by insurers to co-ordinate in any significant way any physical rehabilitation programs with the Workmen's Compensation Board.

The Committee could not help but conclude that the insurance companies seem insincere about rehabilitation and indeed that even the concept of rehabilitation is not clear to them. The Committee expects much more.

69. The Committee recommends that insurers adopt a more positive attitude regarding the rehabilitation of disabled insureds. In this regard, it is to be hoped that some of the Committee's previous suggestions regarding better utilization of regional facilities throughout the Province and the training of qualified personnel to assist in rehabilitation will be matters regarding which insurers will see an opportunity to take a more active role in the rehabilitation of the disabled.

I. SUMMARY

As the Committee noted at the beginning of this chapter the matter of rehabilitation in a disability financial protection plan is a vital one but with many problems associated with it that are difficult to solve. The Committee having had an opportunity to study the matter in some depth is not aware that anyone had designed a complete scheme for rehabilitating the disabled. The Committee does not believe that the scheme proposed for Australia is perfect nor does it believe that a perfect scheme can be devised here. The first step in arriving at a solution, however, lies in a recognition of the problems. From this base, individual problems may be attacked, solutions reached for them and in such a way gradually improve the total system. It is with these thoughts in mind that the Committee has addressed some of its concerns with the present workers' compensation plan as operating in Ontario today with the hope that solutions to specific problems that the Committee perceives may be reached by the Board, the Ministry of Labour and other Ministries of the Government.

At best the Committee, therefore, foresees a piece-meal approach to solving the problems of rehabilitation of the disabled. One of the more important steps in planning and implementing an improved rehabilitation plan in Ontario is to inventory the existing facilities and programs and design means whereby, on a regional basis, better use is made of these facilities by existing rehabilitation organizations and by co-ordinated efforts to make better use of all the resources and funds available. These steps can be taken immediately and as time and other circumstances permit further refinements may be made to the system with the ultimate aim of establishing a comprehensive disability protection plan for all residents of Ontario along the lines of those set out in Chapter 24.

CHAPTER 27

Safety and Prevention

A. INTRODUCTION

In addition to the submissions and presentations made to the Committee by those concerned with matters relating to safety and prevention, the Committee reviewed studies and reports on the subject conducted by others.

The Committee noted with particular interest observations made by the Hon. Emmett M. Hall, CC, QC, in his report “Canada’s National-Provincial Health Program for the 1980’s—‘A Commitment for Renewal’ ” of August 1980 three extracts from which follow:

a) from page 64

“The Economic Benefits of Health Care

This was dealt with fully in Chapter 12, Volume I of the 1964 Commission Report and deserves rereading now. The Commission said at p. 508:

“Lung cancer, cardiac illness, alcoholism, and highway and other accidents, all appear to be, in part, the consequence of individual behaviour. In a sense, more responsible behaviour would eliminate the need for many health expenditures. But having incurred an illness it would still pay an individual to regain his productive position and avoid disability or premature demise. We may regret unwise human behaviour but we have to accept it as a reality of life. We feel that even where the net gain to society is negative, i.e., when output to be expected is less than the costs of health services required, it still is desirable to assist people to regain their health.

and at page 510:

“Absence from work because of illness or injury also imposed heavy burdens on Canadians. The direction of causation may be uncertain, but it is significant that there is a high correlation between the number of days an individual is disabled from illness and the size of his income. Low income and above average illness are still too common an experience in our society. Thus on an average day there are about 2 per cent of the labour force absent from work because of illness and accident during the whole year the total number of days lost through non-disabling physical illness amounted to nearly 34 million or 5.2 days per employed person. Days lost from work as a consequence of total physical disability were estimated to be 53 million and from mental illness, 11.4 million. The cost of such absences is estimated to have been equal to a loss of output of at least \$1,420 million. This was

equivalent to about 3.8 per cent of total output (GNP) and 6.4 per cent of the total civilian payroll. This loss of output was the consequence of a loss of productivity from non-disabling illness among those normally employed amounting to around \$490 million; loss of productivity as a consequence of permanent physical disability amounted to \$765 million; while productivity amounting to an estimated \$165 million was lost as a consequence of mental illness.”

These were 1963 figures. They would be more cost effective today. The estimates given below give food for thought.

Estimated annual work days lost in recent years, using data from the monthly Labour Force Survey, Statistics Canada, are as follows:

Year	Illness	Industrial Disputes
1975	62,296,000	10,972,000
1976	62,717,000	12,116,000
1977	60,996,000	3,172,000
1978	66,716,000	6,552,000”

b) from page 65

“I think it logical to quote here from an article by Professor Aaron Wildavsky published in the Journal of the American Academy of Arts and Science (1977). He wrote:

“According to the Great Equation, Medical Care equals Health. But the Great Equation is wrong. More available medical care does not equal better health. The best estimates are that the medical system (doctors, drugs, hospitals) affects about 10 per cent of the usual indexes for measuring health: whether you live at all (infant mortality), how well you live (days lost due to sickness), how long you live (adult mortality). The remaining 90 per cent are determined by factors over which doctors have little or no control, from individual life-style (smoking, drinking, driving, exercise, worry), to social conditions (income, eating habits, physiological inheritance), to the physical environment (air and water quality). Most of the bad things that happen to people are at present beyond the reach of medicine. Everyone knows that doctors do help. They can mend broken bones, stop infections with drugs, operate successfully on fractures, deformities and tumors. Inoculations, internal infections, and external repairs are other good reasons for keeping doctors, drugs and hospitals around. More of the same, however, is counterproductive. Nobody needs unnecessary operations; and excessive use of drugs can create dependence or allergic reactions or merely enrich the nation’s urine.” (Aaron Wildavsky, *Daedalus*, Journal of the American Academy of Arts and Sciences, Winter 1977)”

c) from page 68

‘‘Self-Help, Mutual Aid and Health

The policy document ‘‘A New Perspective on the Health of Canadians’’ carried the essential message that the Lifestyle (in behaviour) of Canadians and the Environment (Physical and Social) have had and will continue to have a major influence on our health. Even when necessary corrections are made in the Health Care Organization, it remains true that future health improvements come mainly from modifications in the lifestyle and environment of Canadians. It is known that two major premature killers are smoking and hazardous driving—automobiles, snowmobiles, motorcycles, but how can society get rid of these destructive habits.

In a paper prepared by Jean-Marie Romeder and Ruth Watson of the Department of National Health and Welfare, it is said:

‘There are essentially two avenues which can be used to promote such behaviour changes.

The first avenue is to use outside forces such as legal or economic actions designed to modify our environment so that we will act differently. Indeed such actions by government are often warranted, particularly when they attempt to correct certain societal aspects which are leading many individuals to unhealthy behaviours for the profit of a certain minority.

The second avenue corresponds to inside forces or personal motivation. We know that most long-lasting behavioural changes come from inside, from personal motivation, and that outside forces can only facilitate such changes. We have learned that from behavioural sciences and from the observations of many counselors and therapists during the past decades.

But what can government do about it? It is suggested here that the government can facilitate the social environment in which individuals find their own motivation to change certain parts of their lifestyle habits or some aspects of their environment in order to grow and help others to grow healthier. Self-help mutual aid groups are such a means to reach this goal. This is obviously a somewhat new role in health and social policy; we do not suggest to create new direct services, but to recognize, acknowledge, publicize and facilitate through appropriate means the work of thousands of self-help groups already formed by motivated individuals throughout the country.’ ”

Similarly, the Committee read with interest the observations made by the Woodhouse Committee in Australia when dealing with a proposed comprehensive disability financial protection plan for that country when it noted:

“If as we firmly believe the encouragement of a scientific approach to accident prevention and control is fundamental then there must be central planning and central direction. But no organization in Australia comprehends all facets of prevention. The Government Departments both State and Federal, the National Safety Council and numerous voluntary bodies all do fine work. None, however, has a present responsibility for looking in a scientific way at the totality of the accident problem. There is a need for an organization able to take that overall perspective and its purpose would be not to displace groups now concerned with safety and prevention but to assist them. We recommend that the responsibility be given to a newly created National Safety Officer . . . its fundamental purpose should be the articulation of safety goals, substantial financial assistance for State safety projects and voluntary safety organizations, the establishment of a research division, the definition of standards and an integrated attack on the accident problem as a whole.”

B. ECONOMIC BENEFITS OF AN EFFECTIVE SAFETY AND PREVENTION PROGRAM

The aim of safety and prevention programs in the context of sickness and accident protection is to promote general safety, prevent accidents and to minimize injury. To the extent that safety and prevention programs are able to save on medical care and rehabilitation they can be of great economic value to the residents of Ontario. The money that is spent well on safety and prevention programs is going to reduce other costs. On the other hand, if money is spent badly on safety and prevention programs, it is wasted money. The measurement of an effective safety and prevention program is very difficult. A successful program will mean that sickness or accident does not occur. An unsuccessful program likely means that sickness, disease or accident will continue at an unacceptable level.

There is no question from the Committee's point of view that there is a need for effective safety and prevention programs. They are important to society. The ideal should be a safe environment for all residents of the Province at work, at home, at other places and while travelling.

C. SAFETY AND PREVENTION PROGRAMS AS A PART OF A COMPREHENSIVE DISABILITY FINANCIAL PROTECTION PLAN

The Committee has difficulty viewing safety and prevention programs as a necessary component of a comprehensive disability financial protection plan. While the Committee recognizes that the administration of a comprehensive disability financial protection plan will likely permit the gathering of better statistics on sickness, disease and injury, it does not believe that it

follows necessarily that safety and prevention programs need become a specific component of such a plan.

Rather, the Committee views safety and prevention programs as capable of being viewed separately although of necessity integrated with the entire concept of a comprehensive disability financial protection system. The Committee takes this view mainly because of the tremendous onus on individual responsibilities for the success of any safety and prevention program. The Committee acknowledges that it is possible for government, voluntary or private agencies to establish the process by which better safety and prevention can be obtained but the success of the program will lie very heavily on individual responsibility. Perhaps only so much can be done by governments and institutions.

D. CO-ORDINATION OF SAFETY AND PREVENTION PROGRAMS

There are many in Ontario concerned with sickness and accident safety and prevention. Some of these programs were outlined in Part III of this Report. There are government departments and agencies, the private sector, voluntary groups and individual citizens involved in many ways in safety and prevention programs. Most do good work. However, with so many individual safety and prevention programs, there are many groups making demands on the available funds to support such programs. Frequently, it is felt that the "squeaky wheel" gets the grease and in some instances, the program involved may not address the area of greatest concern and need. Such programs in total are expensive and involve substantial government expenditures.

It will continue to be difficult to co-ordinate the number of programs that are required to meet the various safety and prevention needs of the entire community. To assist, however—

70. The Committee recommends that consideration be given to setting up a central agency within the Provincial Department of Health to be responsible to know what is going on in the different sectors regarding safety and prevention programs so that if one group wants to know what others are doing, there would be some place they could find out; the Committee does not envisage the setting up of a new bureaucracy; rather, the Committee contemplates that the central agency it proposes would be an information centre only.

E. ENFORCEMENT OF SAFETY AND PREVENTION PROGRAMS

The Committee has commented on the importance of individual responsibility in the success of safety and prevention programs. In the case of many safety and prevention programs, relying on individual responsibility is not

sufficient and there is need, therefore, for appropriate procedure to enforce safety or prevention instructions, guidelines, regulations and laws. In the end, in most instances, there is a dual responsibility. In the first place, if guidelines are laid down, it is up to the people involved, the employers, the manufacturers and the individual to see that the guidelines are followed. In the second place, however, there is a place for enforcement and inspection.

The Committee is not prepared to recommend a centralized agency such as has been proposed for Australia with the creation of a National Safety Officer with powers commensurate to his position as National Co-ordinator.

71. The Committee believes there is a continuing role for government in Ontario in enforcement of certain safety and prevention programs and recommends to the Ministries responsible that the appropriateness of these enforcement procedures be under constant review. In particular, the Committee believes that it is essential that a constant watch be kept on the health of employees in the work place and more specifically, in certain industries and factories because of the potential chemical, biological or physical hazards in those situations. Employees working in the asbestos products industry, in uranium mining and in nickel refining are typical examples.

The Occupational Health and Safety Act, S.O. 1978, embodies legislation which is strongly endorsed by both workers and management concerning the necessity to maintain complete medical records in order to monitor the health of individual workers in relation to known hazardous substances in the work place and new substances as they are introduced to the work environment. The Act provides that employers establish and maintain occupational health services for workers as prescribed and also keep and maintain accurate records of the exposure of workers to various toxic substances. Workers, for their part, are required to submit to such medical examinations, tests and x-rays as may be required.

The Act also provides for the appointment of a health and safety representative, to be selected by the workers from their ranks, on a construction project at which the number of workers regularly exceeds twenty. Further, except for certain occupations such as teachers, office workers, janitors and shop workers, where twenty or more workers are regularly employed at a work place, a joint health and safety committee must be established, consisting of at least two persons of whom half shall be non-managerial personnel selected by the workers. The function of these health and safety representatives or committees is to identify situations dangerous or hazardous to workers; to make recommendations relating to the physical condition of the work place; and, in general, to exercise wide powers relating to the health of the workers.

Another section of the Occupational Health and Safety Act provides for the prescribing of any biological, chemical or physical agent or combination

thereof as a designated substance and to regulate or prohibit the use of such substances.

72. The Committee fully endorses the concepts set out in the Occupational Health and Safety Act, and in particular, the shift in emphasis which it embodies to the disease or injury to the worker rather than the identification of the fault for his or her disablement. The Committee recommends that the theme of concern with the nature of the disease or injury of the disabled rather than the cause of the disability be one reflected in all legislation affecting the disabled.

F. THE ROLE OF INSURERS AND NON-PROFIT PREPAID MEDICAL CARE ORGANIZATIONS

The Committee acknowledges the sincere efforts made by insurers and the non-profit prepaid medical care organizations in publicizing a number of aspects of accident and sickness safety and prevention. However, the Committee gained the impression that in many respects the various associations representing insurers, the individual insurance companies and non-profit prepaid medical care organizations were developing their programs in isolation.

73. The Committee recommends that the Insurance Bureau of Canada, the Canadian Life and Health Insurance Association and the non-profit prepaid medical care organizations and individual insurance companies make a greater effort to co-ordinate their efforts regarding safety and prevention programs and the education of the residents of Ontario concerning matters relating to safety and sickness and accident prevention. Further, the Committee encourages the insurance industry to take the initiative in co-ordinating their safety and prevention programs with others for example, the Workmen's Compensation Board.

G. SUMMARY

The Committee summarizes its views concerning safety and prevention programs in Ontario as follows:

74. In sum, the Committee encourages safety and prevention programs and the continuing involvement of government, the private sector, voluntary groups and individual citizens in such programs. Participants should be encouraged to co-ordinate their programs with others in the field and the Committee recommends a central agency be established to assist in this co-ordination of effort. The success of most safety and prevention programs, present and future, depends ultimately on the efforts of individual residents. While the Committee encourages groups involved in safety and prevention programs, the onus rests on the individual to know what his or her responsibility is.

CHAPTER 28

Confidentiality of Health Information

The Hon. Mr. Justice Horace Krever made it clear in the “Report of the Royal Commission of Inquiry into The Confidentiality of Health Records” presented on September 30, 1980 to The Minister of Health for the Province that he was far from satisfied with the practices followed by employers and insurers in the handling of health information of employees. As a consequence he made a number of recommendations which appeared in Chapter 30, Volume III of his Report. The Committee has reviewed with great interest Justice Krever’s findings which confirm the Committee’s own observations during its review of the business of insurance in Ontario.

In its Fourth Report on Life Insurance, the Committee commented at some length on matters relating to the collection of rating information and on the privacy and use of personal information ending on Page 245 on the Collection and Confidentiality of Personal Information used for Underwriting Purposes.’’

This section is reproduced below:

“5. Observation on the Collection and Confidentiality of Personal Information used for Underwriting Purposes

In reviewing the practices of the insurance industry in collecting underwriting information on applicants and safeguarding the confidentiality of this information the Committee has come to the following conclusion. Because the life insurance industry makes extensive use of personal information in the underwriting of its products, the Committee concludes that safeguards in use of this information should be provided to the public.

Standards with Respect to Confidentiality and Use of Personal Information

- 7.9 The Committee recommends that standards with respect to the confidentiality and use of personal information collected for underwriting purposes should be set out in regulations to The Insurance Act, with appropriate amendment to the Act to require compliance by the industry and supervision by the Superintendent.

The Committee believes that much work has already been done by the industry both in Canada and in the United States in setting out appropriate standards for safeguarding the privacy of underwriting information. This work should provide the basis for effective privacy standards binding by force of regulation on all insurers licensed in this Province.

7.10 In general terms the Committee recommends that regulations with respect to confidentiality and use of personal information provide that:

- individuals are told what kind of information is being collected about them, how it will be used to whom it will be disclosed;
- individuals should be able to see and obtain a copy of their records and correct any errors;
- individuals should be assured that there will be no improper disclosure of their records;
- individuals should be told the basis for any adverse underwriting decision that may be based on personal data.

Written Notice of Reasons for Adverse Underwriting Decision

7.11 As a specific matter related to use of personal information, the Committee recommends that every denial or adverse rating of an application for life insurance should be accompanied by a formal written notice delivered to the applicant stating the reason or reasons for the adverse underwriting decision. The Committee recommends that this requirement be incorporated into The Insurance Act as a separate duty of life insurers under Part V of the Act or as part of the regulations previously recommended in regard to standards of confidentiality and use of personal information.

In regard to this recommendation, the Committee recognized a possible problem in that insurers and agents may tend to increase the use of the “informal application” to avoid the notification requirement and generally to avoid the processing of applications which are unlikely to result in policy issue. This practice may prove to be difficult to detect and measure and hence to enforce if its continuance were prohibited.

It is the Committee’s view that this means of doing business is not one which would be adopted by a mature industry.

7.12 The Committee expects that the life insurance industry in this Province will prove regulations prohibiting informal applications are not required. That is the Committee expects that all life insurance companies will treat each enquiry about a life insurance plan as an application to the extent of notifying the prospective purchaser in writing of the reasons for policy denial or adverse rating.

Should the Superintendent obtain evidence of any increase in the use of informal applications by insurers to escape the obligation to notify prospective policyholders in regard to the insurer’s decision to deny an applicant coverage or rate the applicant as a substandard risk, then

the Committee recommends that the Superintendent consider the statutory requirement that no insurer can refuse to state the reason for denial or substandard rating of coverage to a person who believes he has applied for coverage, even if such application is treated informally. Appropriate protection might be afforded to the insurer in certain circumstances when denial or rating of coverage may be based on reasons such as suspicion of criminal activities by the "applicant".

The Medical Information Bureau

The Committee is concerned about the confidentiality and use of personal information held by industry-support organizations, such as the Medical Information Bureau. The Committee has examined the reliance of the life insurance industry on the M.I.B. and has enquired about the operations of the M.I.B.

7.13 The Committee is generally satisfied that the standards of the M.I.B. with respect to confidentiality of the information which it collects and files are quite strict and a reasonable protection to life insurance applicants and policyholders. Of concern to a number of members on the Committee is the reliance of life insurance companies in Canada on an industry-support organization located in the United States. While the Committee would prefer to see personal information on Canadians remain with an organization indigenous to Canada, the Committee is for the present time satisfied that the interests of Canadian and Ontario policyholders can be protected by mandatory standards of personal information use and disclosure applied to life insurance companies licensed in this Province.

7.14 The Committee therefore recommends that mandatory standards of personal information use and disclosure applicable to insurance companies should be formulated so as to control the privacy of information held by industry-support organizations such as M.I.B. who derive their information from the life insurance industry. The Committee recommends that an appropriate requirement in this regard could provide that each insurance company should exercise reasonable care in the selection and use of insurance support organizations, so as to assure that the practices of such organizations comply with the privacy standards set out in regulations to The Insurance Act."

The Committee has repeated these observations and recommendations as it believes they are equally applicable to its current study as to its review of the life insurance portion of the business of insurance.

75. The Committee believes that its recommendations 7.9 to 7.14 contained in its Fourth Report on Life Insurance and relating to

“standards with respect to the confidentiality and use of personal information”; “written notice of reasons for adverse underwriting decisions”; and “The Medical Information Bureau” are equally applicable to sickness and accident insurance and the safeguards in the use of personal information that should be provided to the public.

The Committee is also pleased to lend its support to the recommendations made by Justice Krever in regard to the confidentiality of employee health information. For reference purposes Justice Krever’s recommendations No. 107 to 141 contained in Chapter 30 of his Report are appended to this Report as Appendix I.

76. The Committee recommends that the Minister of Health take prompt action to implement recommendations 107 to 141 contained in the Report of the Health Information, Commission of Inquiry into the confidentiality of employee health information by The Hon. Mr. Justice Horace Krever, Commissioner.

CHAPTER 29

Summary of Recommendations

In this chapter the Committee summarizes the recommendations contained in Chapters 22 to 28 in this Part. Readers are referred to these earlier chapters to place each recommendation in its proper context.

CHAPTER 22. - FINANCIAL PROTECTION AGAINST THE COSTS OF MEDICAL CARE

1. The Committee recommends that OHIP carry out careful analyses of exclusions from "insured services" and consider, for example, among other matters;

- (a) transportation costs of those in Northern Ontario requiring medical care and treatment;

The Committee recommends that this particular subject be given high priority by OHIP since it is generally recognized that residents of Northern Ontario do not get as good service as other residents of the Province because of their isolation and the fact that services are not generally available. In this regard, the Committee is cognisant of the concern expressed by some that, if payment of transportation costs is readily available to residents of the north, there will be less incentive than ever for doctors to move to the north and possibly there will also be less emphasis on developing adequate medical care facilities in the area.

- (b) significant transportation costs, other than by ambulance, of those requiring medical care and treatment that is only available at specialized hospitals and treatment centres;
 - (c) certain prescription drugs such as serums, injectibles and insulin;
 - (d) artificial limbs;
 - (e) braces;
 - (f) boots, splints and trusses;
 - (g) wheelchairs, crutches, canes and walkers;
 - (h) other prosthetic devices;
 - (i) respirators;
 - (j) hearing aids for children;
 - (k) eyeglasses for children;

- (l) corrective eye surgery for children;
 - (m) cosmetic surgery for children;
 - (n) acupuncture;
2. It is recommended that OHIP be required to report to the Minister of Health and to the Assembly on the results of their analyses as they relate to the needs for each of these services and the cost implication of adding them to "insured services" provided by OHIP.
 3. The Committee also recommends that analyses similar to those set out in its first recommendation be undertaken on a regular basis with the intent of ensuring that there is a constant review and regular reporting to the Minister of Health on the possible extension of insured services by OHIP. The report on this matter should be included in the regular report of the Ministry of Health produced each year.
 4. The Committee recommends that OHIP adopt an attitude of being more liberal in considering individual cases and applying greater discretion in assessing each case with the general aim of extending as far as practicable the services for which it is prepared to reimburse residents for the medical care costs they incur. The Committee encourages OHIP to adopt a more generous attitude in its interpretation of reimbursable transportation costs and costs of cosmetic surgery.
 5. The Committee recommends that a question be included on the Ontario portion of personal income tax returns inquiring "Are you covered by OHIP, either individually or in a group plan?"
 6. It is also recommended that OHIP conduct an annual campaign at a specified time each year, encouraging those who are not participating in OHIP to do so.
 7. The Committee recommends that improvement be made in the insured services covered by OHIP with the ultimate aim of establishing a common level of benefits for all residents of Ontario requiring medical care.
 8. The Committee recommends, contrary to the suggestion of Professor Weiler contained in his report "Reshaping Workers' Compensation for Ontario", that the Workmen's Compensation Board continue to have its own records of work-related injuries and industrial disease and not pass the responsibility for maintaining any relevant records to OHIP.
 9. The Committee recommends the application of a better process of establishing the negotiated OHIP schedule of fees for doctors'

services. These rates must be seen to be fair both to the doctors and the residents of Ontario through their negotiator OHIP. It may be that appropriate arbitration procedures is where the answer lies.

10. The Committee recommends that user fees not be introduced into the health-care system of the Province and that the arguments for the use of such fees as a means of controlling the utilization of services, of cost containment and of providing "reasonable compensation" to medical practitioners be rejected.
11. The Committee must express the urgency of its concern and the consensus that it reached that the present Medicare system in Ontario not be allowed to collapse. The Committee believes that the solution to the current problem of excess billing by certain medical practitioners lies in give on both the side of the government through OHIP and the medical practitioners to arrive at a schedule of fees acceptable to both that will ensure that Medicare continues for the benefit of the residents of Ontario. The Committee recommends that steps be taken immediately by both sides to ensure resolution of their differences.
12. The Committee recommends that insurers and the non-profit pre-paid medical care organizations continue to be prohibited to sell coverage for excess billings for OHIP insured services. To do otherwise would lead to two separate systems of medical care in the Province and destroy the concept of "furnishing of insured services upon uniform terms and conditions to all insured residents of the province" in which the Committee firmly believes.
13. The Committee recommends that the regulations under The Health Discipline Act, 1974 in a reference to "professional misconduct" be amended to include "charging a fee that is in excess of the fee listed in the current OHIP fee schedule, without prior notification to the patient as to the excess amount of the fee."
14. The Committee recommends that the Insurance Bureau of Canada reconsider portions of its general bulletin concerning Christian Science treatment and automobile insurance that deals with payments for services as requiring that both the insured's attending physician and the insurer's own medical advisor agree that the treatment is essential. The Committee suggests that this portion of the bulletin might be amended by deleting reference to the insured's attending physician and made to read as follows:

"That payments for the service of Christian Science practitioners would be payable when the insured's own medical advisor agrees that such treatment is essential for the treatment or rehabilitation of that person."

15. The Committee emphasizes that in its view insurers and non-profit prepaid medical care organizations have a responsibility to make extended health care plans more available to those outside recognized groups. Insurers in the past have been successful in developing pooling arrangements for other lines of insurance and the Committee recommends that the insurance industry develop a similar type of pooling arrangement for providing extended health care plans to individuals.
16. The Committee recommends that the industry move to a three-month waiting period as used by OHIP as a generally more acceptable method of controlling abuses and anti-selection.
17. Since medical expense coverage provided by automobile rental agencies duplicates coverage available to residents of Ontario through OHIP, the Committee recommends that regulations be passed to indicate that medical care coverage at the time of renting an automobile is not required for residents of Ontario. The regulations should contain provisions for the noting of this fact prominently on all rental agreements and other appropriate forms used by rental agencies.
18. The Committee also recommends that automobile rental agencies be required to disclose the amount of the third-party liability coverage they have and the cost of any additional coverage of which the renter of the automobile may wish to avail himself.
19. The Committee recommends that non-profit prepaid medical care organizations continue to be regulated under separate statute, The Prepaid Hospital and Medical Services Act.
20. However, the Committee recommends that the Prepaid Hospital and Medical Services Act be amended as appropriate to provide to the Superintendent of Insurance the same powers over the non-profit prepaid medical care organizations as are provided to him under The Insurance Act regarding the supervision of insurance companies.
21. The Committee also recommends that no change be made that would remove the exemption from premium taxes on the premiums collected by the non-profit prepaid medical care organizations.
22. The Committee recommends that, with the exception of the non-profit prepaid medical care organizations, all other insurance type plans be administered under provisions of The Insurance Act. The Committee has in mind such plans as prepaid legal and association sponsored prepaid dental plans.
23. The Committee recommends that the provisions of The Insurance Act be extended to provide for suitable solvency, reporting and security provisions as may be appropriate in order to provide

protection to the potential beneficiaries under all insurance type plans and ensure that the benefits promised will be delivered when required. The Committee envisages that The Insurance Act will be amended as appropriate to ensure that these requirements are extended to, among others, administrative services only plans, self-insurance plans and plans organized by labour unions.

24. It is not the Committee's wish to stifle in any way initiative in the design of insurance type plans and therefore the Committee recommends that the capital and deposit requirements to be applicable to various types of plans be defined in terms that may be appropriate to individual circumstances rather than requiring conformity to stringent and possibly prohibitive capital and deposit requirements made applicable to all.
25. The Committee is not prepared to make specific recommendations concerning the application of premium taxes to all of the plans that it is recommending should now be brought under The Insurance Act. The Committee is prepared to leave the matter as to whether premium taxes should or should not be applicable to administrative services only, self-insurance and union plans to the Minister of Revenue as he may determine is appropriate and desirable.

CHAPTER 23 — FINANCIAL PROTECTION AGAINST THE COST OF DENTAL CARE

26. The Committee recommends that the Minister of Health give high priority to the introduction of a comprehensive dental care plan for children of Ontario, phasing in the plan as may be appropriate with the ultimate aim of covering all children under the age of eighteen for preventive and maintenance dental work, orthodontic services and major restorative procedures. The Committee recognizes that current economic conditions may make it impossible to introduce such a plan at the moment but it believes that the Minister should undertake the accumulation of statistical and other data necessary to develop an implementation program for such a comprehensive dental plan even though it may be impractical to introduce such a plan immediately.
27. While excess billing by dentists is of far less significance than excess billing by doctors to residents of Ontario and to the concept of universal medicare, the Committee's concerns extend to the opting-out of dentists and the excess billing by them. The Committee stresses the importance of resolving the current problem and ensuring reasonable access to insured services by insured persons under OHIP while at the same time providing reasonable compensation for insured services to practitioners. The Committee recom-

mends that the government through OHIP and the dentists take steps immediately to arrive at a mutually acceptable schedule of fees for services and ensure that Medicare continues for the benefit of the residents of Ontario.

28. The Committee repeats its recommendation that the aim in Ontario should be for a common level of benefits for all residents including dental care services without regard to the cause of the need for these dental services. In due course, a comprehensive disability income protection system for the residents of Ontario should include dental care. The Committee has already expressed the view that the place to begin is with a comprehensive plan for children with a second priority given to specific hardships cases.
29. The Committee recommends further that the comprehensive plan it is recommending begin with all children in the Province should be designed on the basic premise of a common standard of dental care for all.
30. The Committee would be pleased to see the private sector develop a pooling arrangement of some kind whereby it might be able to extend dental care coverage to those who do not make up appropriate affinity groups under present group plans. The Committee encourages and recommends that the private sector demonstrate initiative in this regard in view of the aim that it has expressed for a comprehensive basic plan available to all residents of Ontario in the future.
31. The Committee recommends that insurers and the non-profit prepaid medical care organizations take a more flexible attitude in the enforcement of standard conditions in connection with the settlement of claims for dental care. In particular, the Committee recommends the industry apply more individual judgment regarding the duration of treatment and limitation for the commencement of services in the case of children.
32. The Committee recommends that appropriate revisions be made to The Insurance Act to remove the exemption of trade unions and to provide the Superintendent with the powers, the Minister believes he should have over any insurance type plan to protect the consumer regarding the solvency of such plans and to ensure benefits provided to the participants in such plans will be delivered when required. The Superintendent should have authority to require accurate reporting of information and compliance with appropriate solvency, deposit or guarantee requirements as the Superintendent might deem appropriate. Essentially, the Committee believes that if money is advanced in the expectation of receipt of services to be delivered later, there is a role for the Superintendent.

CHAPTER 24 — CONSIDERATIONS REGARDING A COMPREHENSIVE DISABILITY INCOME PROTECTION SYSTEM

33. The Committee recommends that the focus of disability income protection be shifted from the cause of the disability to the severity or duration of the disability. Essentially, the problem with the present system is that the eligibility and level of income protection is frequently dependent upon how or where the disability occurred rather than the disability itself. The focus must be shifted from “cause—the how and where”—to the “degree and extent and what happened”.
34. The Committee recommends that an interministerial committee be established as soon as practical to examine the problems and possible solutions to the introduction of a comprehensive disability income protection plan for residents of Ontario.
35. The Committee recommends that it may be appropriate to introduce a comprehensive disability financial protection plan for the residents of Ontario in stages. One way is to introduce the program to different groups of people. For example, in this “International Year of Disabled Persons”, the Committee considers it reasonable to introduce a comprehensive income protection plan for all those with certain congenital defects. It might be worthy then, to design and implement a comprehensive program for the self-employed, although the Committee recognizes that this is a particularly difficult area. Another way of introducing a comprehensive plan by stages would be to follow the lead taken by some other jurisdictions who have introduced a comprehensive plan covering all those disabled by way of accident as a first stage to be followed at a later stage with a program designed to cover those disabled as a result of sickness.
36. The Committee recommends that any comprehensive disability financial protection plan would be applicable to residents whether they are at home or out of the country.
37. The Committee believes that the concept of a comprehensive disability financial protection plan for Ontarians should be that there will be as few exceptions as possible regarding the cause of disability and these only on the basis of clear principles.
38. In a comprehensive financial protection system, the Committee cannot see any merit in attempting to maintain separate and distinct funds and account for the operations of each fund separately. On the contrary, the Committee believes that the premise of consistent and uniform treatment for all residents requiring disability income protection would be served better if the plan were treated as one plan and accounted for on that basis.

39. In this connection, however, financing the plan is another consideration. Some are of the opinion that the most reasonable approach would be to finance the entire plan out of general taxation. Others believe that financing a comprehensive plan should be based upon a continuation of the principles of workers' compensation premiums being paid by employers and automobile insurance premiums being paid by the users of motor vehicles. On balance, the Committee recommends that the principle of three sources of financing—employers' contributions similar to workers' compensation premiums; motor vehicle users' contributions similar to automobile insurance premiums; and, general contributions by way of taxation as is the case for many of the present public programs.
40. The Committee repeats the recommendation contained in its Second Report and recommends that as a general concept "fault" no longer be the fundamental factor to be considered in determining whether compensation should be paid in the case of losses due to accident or disability.
41. The Committee has previously indicated that it is not prepared, at this time, to recommend the elimination of all lump-sum payments although it does believe that periodic payments is the most satisfactory way of paying claims for all concerned.
42. The Committee recommends that periodic benefits should be taxable in the hands of the recipient. On the other hand, if a level of lump-sum payments is retained in the plan to compensate victims of injury for pain and suffering and loss of amenities, the Committee believes that these lump-sum payments should be non-taxable.
43. The Committee recommends that an essential provision of a comprehensive disability financial protection plan be to provide for benefit payments to the disabled at a high maximum level that would be closely related to the normal earnings of anyone disabled in the Province regardless of the level of earnings reached during employment. The concept of the plan cannot be built on one of providing basic or minimal income protection.
44. In this connection, the Committee further recommends that, in the case of homemakers and others not in receipt of earnings, income benefits be based on notional income levels as future studies may indicate may be appropriate.
45. The Committee recommends that the design of any disability income protection plan provide for the automatic adjustment of benefits on a regular basis with such adjustments possibly based on increases in the cost of living or increases in average industrial wages. The Committee's recommendation in this regard is tempered

by a very real concern it has concerning indexing benefits and that by the process of such indexing, it is "institutionalizing inflation".

46. The Committee believes that provision should be made in any comprehensive plan for the payment of reasonable funeral expenses.
47. The Committee also recommends provision be made in any comprehensive plan for the payment of modest death benefits to provide for the transitional adjustments of survivors.
48. The Committee recommends that individuals be permitted to purchase insurance for additional coverage that they may consider necessary in their particular circumstances over the maximum level of benefit payments stipulated in the disability financial protection plan.
49. The Committee recommends that, in addition to the medical rehabilitation of the disabled, the design of a comprehensive plan for Ontarians give much more consideration than has been the case in the past to other aspects of rehabilitation, in particular psychological, vocational, educational, recreational and social rehabilitation.
50. In matters relating to the rehabilitation of the disabled, the Committee reemphasizes the theme that it believes is basic to a well-conceived, comprehensive disability financial protection program that of seeing that assessments are individualized and take into account the whole person.
51. The Committee recommends that with the introduction of a comprehensive plan in Ontario, employers be required by law to continue to pay injured or sick workers for the first few days of their disability so long as there are adequate safeguards provided to prevent abuse by employees.
52. The Committee recommends that any comprehensive disability financial protection plan provides an appropriate appeal mechanism so that once a judgmental decision is made under the plan, the disabled person would have the right to go somewhere else to have his or her case heard if he or she is not satisfied.
53. The Committee recommends that a comprehensive disability financial protection plan would anticipate the dropping of income protection provisions during periods of disability from both the Unemployment Insurance and Canada Pension Plan programs.
54. The Committee recommends that a comprehensive disability financial protection plan be based on the concept of pay-as-you-go with revenues in any one year designed to match the necessary expenditures in that year anticipating neither a "profit" nor a "loss" on the operations of any one year.

CHAPTER 25 — DISABILITY INCOME PROTECTION — IMPROVING THE PRESENT SYSTEM

55. The Committee encourages the insurance industry to reassess their policy with regard to indexing of income benefits particularly for those suffering long-term disability whose income and standard of living may have deteriorated as a result of inflation and who are without recourse.
56. The Committee recommends the level of funeral benefits paid under both government and private plans be reviewed on a regular basis so that they may be kept more closely in step with the costs of a basic funeral.
57. The Committee recommends that an appropriate interministerial committee be instructed to review the various definitions of disability in legislation and their application in practice and report to the Assembly through the Minister of Labour during the next session of the House.
58. The Committee recommends that Statutory Condition 4, reference sections 249 and 250 of The Insurance Act be eliminated from The Insurance Act with the aim of reducing over-insurance on the part of individuals.
59. In recommending the elimination of Statutory Condition 4, the Committee supports the view expressed by the Superintendent of Insurance during its hearings and recommends further that he oversee the insurance industry as it makes the necessary adjustments in premiums, possibly including any refund of premiums, to policyholders and in general the orderly transition that will be involved in this change.
60. The Committee recommends that beneficiaries be given the option to accept the disability income provision of group life policies or to leave their group life insurance intact as opposed to being denied this latter alternative as at present. The Committee reiterates that there should be a comprehensive disability financial protection plan for all residents of Ontario providing a level of benefits adequate to sustain the standard of living at a high maximum level. Acceptance of this concept is incompatible with the need for the disabled to use their life insurance coverage to maintain income during periods of disability.

CHAPTER 26 — REHABILITATION AND THE DURATION AND TERMINATION OF DISABILITY INCOME PROTECTION

61. The Committee reiterates its concern regarding the inadequate vocational rehabilitation and psychiatric assistance provided to the

disabled by the Workmen's Compensation Board and recommends to the Board that more attention be devoted to these important areas of rehabilitating disabled workers.

62. The Committee recommends that the Chairman of the Workmen's Compensation Board carry out a searching scrutiny as he considers the Board's future and reassess its mandate along the lines he discussed before the Committee, and that the review keep in mind the importance of considering all aspects of rehabilitation of the disabled and the expense involved, so that the information will be of value not only to the Board in dealing with injured workers but to others concerned with the rehabilitation of those disabled by other than by work-related injury or disease.
63. The Committee recommends that the Ministry of Education and the Ministry of Health undertake immediately studies and initiate programs to establish training courses in appropriate educational and other facilities designed to ensure that personnel will be available to assist the disabled in matters relating to their vocational, social, economic and psychological rehabilitation.
64. The Committee recommends that an inventory of rehabilitation resources be prepared for the Province as a whole and for the various regions of the Province. With such an inventory, a focus can be provided for voluntary groups on a regional basis. Better utilization of the facilities and co-ordination of the efforts of all groups could be expected to be of almost immediate benefit to the disabled.
65. The Committee recommends that the Minister of Labour introduce legislation requiring designated employers in the Province to employ a mandatory quota of disabled persons.
66. The Committee recommends that the Workmen's Compensation Board encourage companies to take disabled persons back on their payroll by perhaps offering them an adjustment of their workers' compensation rating.
67. The Committee recommends that matters of persons displaced because of disability be dealt with under the auspices of the Department of Manpower who likely have more specific expertise relating to displaced persons and their re-employment than does the Workmen's Compensation Board.
68. The Committee recommends that appropriate amendments be made to the Human Rights Code to ensure that an individual's disability will not be a determining factor in hiring or firing, or in treatment in employment.
69. The Committee recommends that insurers adopt a more positive attitude regarding the rehabilitation of disabled insureds. In this

regard, it is to be hoped that some of the Committee's previous suggestions regarding better utilization of regional facilities throughout the Province and the training of qualified personnel to assist in rehabilitation will be matters regarding which insurers will see an opportunity to take a more active role in the rehabilitation of the disabled.

CHAPTER 27 — SAFETY AND PREVENTION

70. The Committee recommends that consideration be given to setting up a central agency within the Provincial Department of Health to be responsible to know what is going on in the different sectors regarding safety and prevention programs so that if one group wants to know what others are doing, there would be some place they could find out; the Committee does not envisage the setting up of a new bureaucracy; rather, the Committee contemplates that the central agency it proposes would be an information centre only.
71. The Committee believes there is a continuing role for government in Ontario in enforcement of certain safety and prevention programs and recommends to the Ministries responsible that the appropriateness of these enforcement procedures be under constant review. In particular, the Committee believes that it is essential that a constant watch be kept on the health of employees in the work place and more specifically, in certain industries and factories because of the potential chemical, biological or physical hazards in those situations. Employees working in the asbestos products industry, in uranium mining and in nickel refining are typical examples.
72. The Committee fully endorses the concepts set out in the Occupational Health and Safety Act, and in particular, the shift in emphasis which it embodies to the disease or injury to the worker rather than the identification of the fault for his or her disablement. The Committee recommends that the theme of concern with the nature of the disease or injury of the disabled rather than the cause of the disability be one reflected in all legislation affecting the disabled.
73. The Committee recommends that the Insurance Bureau of Canada, the Canadian Life and Health Insurance Association and the non-profit prepaid medical care organizations and individual insurance companies make a greater effort to co-ordinate their efforts regarding safety and prevention programs and the education of the residents of Ontario concerning matters relating to safety and sickness and accident prevention. Further, the Committee encourages the insurance industry to take the initiative in co-ordinating their safety and prevention programs with others for example, the Workmen's Compensation Board.

74. In sum, the Committee encourages safety and prevention programs and the continuing involvement of government, the private sector, voluntary groups and individual citizens in such programs. Participants should be encouraged to co-ordinate their programs with others in the field and the Committee recommends a central agency be established to assist in this co-ordination of effort. The success of most safety and prevention programs, present and future, depends ultimately on the efforts of individual residents. While the Committee encourages groups involved in safety and prevention programs, the onus rests on the individual to know what his or her responsibility is.

CHAPTER 28 — CONFIDENTIALITY OF HEALTH INFORMATION

75. The Committee believes that its recommendations 7.9 to 7.14 contained in its Fourth Report on Life Insurance and relating to “standards with respect to the confidentiality and use of personal information”; “written notice of reasons for adverse underwriting decisions”; and “The Medical Information Bureau” are equally applicable to sickness and accident insurance and the safeguards in the use of personal information that should be provided to the public.
76. The Committee recommends that the Minister of Health take prompt action to implement recommendations 107 to 141 contained in the Report of the Health Information, Commission of Inquiry into the confidentiality of employee health information by The Hon. Mr. Justice Horace Krever, Commissioner.

PART VII

OBSERVATIONS ON THE
COMMITTEE'S REVIEW OF THE
BUSINESS OF INSURANCE IN ONTARIO 1976-1981

CHAPTER 30

An Overview

A. INTRODUCTION

On May 25, 1976, the Select Committee on Company Law was reconstituted to enquire and review the law relating to the business of insurance companies and other participants in the business of insurance in the Province. With this its Fifth Report on its enquiry and review, the Committee has completed its work.

In the intervening five and one-half years, the Committee has been able to carry out with reasonable thoroughness a review of most of the aspects of the complex business of insurance in the Province of Ontario. The Committee, in various public sessions, has assembled from industry participants, consumers, regulatory authorities and other interested parties, various perspectives and sufficient information on the many facets of the industry to allow it to identify problems and concerns, to reach its conclusions regarding these matters, and to formulate its recommendations and suggestions for improvements. Throughout its review, the Committee has taken the attitude that in order to write good law concerning the insurance industry, it is important to understand the operations of the industry.

In the Committee's opinion, it is worthy of note that in the period 1976-1981, the Select Committee on Company Law has been an all-party committee. Further, it is only on rare occasions that unanimous consensus has not been reached regarding the Committee's recommendations. There have been only two occasions on which dissent of any proportion was registered—first, by the New Democratic Party members of the Committee who did not agree with the majority conclusion reached by the Committee “that Ontario can be better served under a system of automobile insurance operating within the private sector than by the adoption of a government automobile insurance system” and second, by several members who did not concur with the majority conclusion “that ‘fault’ should no longer be the fundamental factor to be considered in determining whether compensation should be paid for motor vehicle losses”.

In the remainder of this Part, the Committee will comment on a number of matters regarding its enquiry and review during the past five years and the five reports that it has issued on various aspects of the business of insurance.

B. THEME OF THE COMMITTEE'S SUGGESTIONS AND RECOMMENDATIONS IN ITS REPORTS

It was noted earlier in this Report that insurance products by their nature are intangible—the evidence for which is a legal document. For payment in advance, they call for the delivery of benefits at some future date. It is these

considerations and the essential nature of the insurance product itself that have made it necessary for governments to take a regulatory role in supervising the insurance industry in order to provide some assurance to consumers that the product, as promised, will be delivered. Acknowledging the need for a government presence in the regulation of the insurance industry, the Committee has attempted to maintain a consistent theme throughout its reports by following three key guidelines. These guidelines were set out in Chapter 1, Page 12 of the Committee's Fourth Report as follows:

- “(a) The government presence in the insurance industry should devote explicit attention to the consumers’ needs.
- b) The government presence should not unduly burden the private insurance industry by over-regulation.
- c) The private insurance industry must demonstrate its commitment to providing protection against risks at a reasonable price to all citizens of the Province of Ontario.”

C. TYPES OF RECOMMENDATIONS MADE BY THE COMMITTEE IN ITS REPORTS

On the same page in its Fourth Report as referred to above, the Committee went on to explain the types of recommendations it made concerning life insurance and explained that these recommendations were of the same type as used in its first three reports. The appropriate paragraphs are repeated here as enunciating the approach the Committee has also taken in making its recommendations in this, its Fifth Report.

“Accordingly, the Committee makes two series of recommendations. The first series consists of proposals to guide the insurance industry in improving the insurance system. The second consists of a number of recommendations that call for direct government involvement in making certain explicit and fundamental changes in the insurance system.

The first series of recommendations recognizes that there is an onus on insurers to market with consumer satisfaction in mind, just as there is an onus on consumers to shop wisely. As in its previous Reports, the Committee attempts in this Report to point out, from its investigations, areas requiring increased insurer attention toward improved consumer satisfaction. At the same time, the Committee believes that the life insurance industry is a mature industry and is capable of striving to meet consumer needs. The alternatives, should the industry fail in its obligations to the consumer, are seen by the Committee to be:

- the government fostering improvements in the industry-operated insurance system,

- the government regulating the actions of the industry in varying degrees short of discouraging its existence, or
- the government meeting the need for protection through a publicly administered insurance mechanism.

The second series of recommendations recognizes that an overlap exists between social or government responsibility in the event of a loss and individual responsibility in pre-planning for the consequences of injury or loss. A voluntary market for insurance does not necessarily ensure that acceptable levels of protection are available to all, principally to third parties. In previous Reports on insurance, the Committee concluded that the government should step in to impose explicit requirements on the insurance system, for example, through compulsory automobile insurance. Likewise, in the life insurance sector, the Committee concludes that explicit measures are needed to improve the consumer's ability to purchase products appropriate to his and his dependants' protection needs.

Clearly in recommending the imposition of explicit requirements on the life insurance system the Committee is in conflict with the concept of minimum regulation. Nevertheless, it is the Committee's conclusion that, in certain cases, the government emphasis must fall most emphatically on consumer or public needs. It is this conclusion which leads the Committee to recommend in this Report a mandatory system of disclosure in the sale of life insurance and to set out further recommendations for changes in The Insurance Act and the regulations thereunder, and for changes in the authority and responsibility of the Superintendent of Insurance in this Province.'

By way of further explanation, the Committee has throughout its Report attempted as far as practicable to offer suggestions for improvement rather than to make recommendations. Specific recommendations have been made only as required and then generally not precise as to form since these matters, in the Committee's view, are best left to the Superintendent of Insurance for the Province to implement. Any recommendations the Committee has made have been designed to provide intent and direction where improvements, in the Committee's view, are needed.

D. RESPONSES TO THE COMMITTEE'S RECOMMENDATIONS

The Committee is pleased with the responses of the Superintendent of Insurance for the Province, the Ministry of Consumer and Corporate Affairs and other Ministries in implementing recommendations it has made. The Committee is also very gratified at the co-operation that the insurance industry and other participants in the business of insurance have given in taking steps to implement its suggestions and recommendations. The Committee looks for all those involved to continue their efforts to improve the

insurance system in Ontario for the benefit of the citizens of the Province. The Committee trusts that this work will continue in a spirit of co-operation of all participants.

The Committee will comment below on specific responses to some of the recommendations in its Reports, in particular, the earlier reports on automobile insurance and general insurance. In general, however, the Committee is encouraged to learn from both the Superintendent and industry representative that substantially all its recommendations have been or are in the process of being implemented although, in a few instances, not in the precise form as outlined by the Committee. In this regard, the Committee had recognized that certain of its recommendations might involve additional costs, the amount of which could not be estimated by the Committee and that it would be necessary to balance these costs when known more definitely against the potential benefit.

Responses to the Committee's Recommendations in its First and Second Reports on Automobile Insurance

The Committee's two reports on automobile insurance were issued in 1977 and 1978. In the period since that time the government and industry participants have taken steps to implement substantially all of the recommendations that were made. While no attempt will be made to discuss each recommendation or the details of the precise form of the steps that have been taken to implement them, brief comments follow concerning a number of the suggestions and recommendations and their disposition.

- Probably the most important recommendation contained in the Committee's first two reports concerned the recommendation that "every person who owns a licensed automobile be required to have a valid policy of automobile insurance providing third party liability coverage and accident benefit coverage". This recommendation was implemented effective March 1, 1980.
- At the same time, the Committee recommended that all third-party liability coverage be increased from the then minimum of \$100,000 to an unlimited amount. In response, the mandatory limit has been increased to \$200,000 which the Committee acknowledges as at least a step in the right direction.
- With the implementation of compulsory third-party automobile insurance the Committee recognized that there would continue to be some drivers who would still remain uninsured and that it would be necessary to continue the Motor Vehicle Accident Claim Fund to compensate the victims of the uninsured or unidentified driver.
- In response to this concern the Committee commends the initiative taken by the Superintendent and the Minister whereby The Compul-

sory Automobile Insurance Act Part II—Amendments to The Insurance Act, in Section 16 (3), repealed Section 230 of the Act and substituted a requirement that every motor vehicle liability policy provide uninsured automobile coverage. At the same time a new regulation was made under The Insurance Act concerning the specific terms, provisions, exclusions and limits of the new coverage. In this manner the need for the Motor Vehicle Accident Claims Fund has been practically eliminated. It is a distinct possibility that the insurance industry will, in the near future, take over what is left of the MVACF and eliminate the need for it.

- Further, the Superintendent's Advisory Committee which consists of representatives of the Office of the Superintendent and the insurance industry have developed an automobile standard endorsement designed to protect an insured motorist in the event of a claim involving a motorist who is carrying less insurance than he or she is. For a very modest premium the motorist desiring the additional benefits may obtain coverage for the difference between the liability coverage of his or her own policy and that of the motorist at fault.
- In order to ensure that all motorists in Ontario are able to obtain insurance coverage, the industry has organized a Facility Association. The Association establishes its own rate schedule which must be approved by the Superintendent. The Superintendent provides an opportunity for public comment on the proposed rate structure by advertising the fact that the proposed rates are available for public review at the time they are to be considered by him.
- A pilot insurance verification program has recently been completed in Metropolitan Toronto involving 1,000 motorists. This program confirmed that 93.5% of the liability insurance cards produced were valid. It is believed that of the remaining 6.5% some may involve errors in recording data at the time of the verification and these situations are being followed up. Those motorists found to have been uninsured are to be charged. The Committee encourages this initiative and recommends that the results of such verification programs be widely publicized.
- The OHIP subrogation arrangement with the insurance companies has been implemented as recommended by the Committee and is working satisfactorily with monthly payments to OHIP of 2 percent of direct written automobile third-party liability premiums having replaced case by case subrogation.
- The accident benefits coverage has been increased generally as recommended by the Committee. Weekly total disability benefits have risen from \$70 to \$140 per week. The maximum limit for medical and rehabilitation benefits has been increased from \$5,000 to

\$25,000. The amount payable to cover the cost of the funeral of a person killed in an accident has been increased from \$500 to \$1,000. Further, the death benefits have been equalized at \$10,000 in the case of persons killed in accidents for either spouse, irrespective of whether it has been the husband or wife who has been killed. In this connection the "common-law" spouse definition from the Family Law Reform Act has been included.

- Regarding the rating classification system the Committee notes that some minor changes have been made to eliminate a few areas of discrimination relating to age and marital status. The Committee, however, still expects much more to be done and encourages the Superintendent and the industry to continue as rapidly as possible with the studies and analyses that are currently under way to develop alternatives to age, sex and marital status as underwriting criteria.
- In a related matter, the Superintendent has undertaken a "conviction surcharge study" in an effort to develop data concerning the possible correlation between drivers with demerit point convictions and auto insurance risk. Extracts from a recent report prepared by the Office of the Superintendent follow:

"That drivers with convictions were in general higher automobile insurance risks than conviction free drivers. The difference was especially marked for vehicles currently rated as five years claim free or three years claim free by their insurer. Such vehicles driven by a principal operator with at least one conviction in the previous three years had approximately a 50% higher chance of incurring a third party liability claim within the next year than cars driven by conviction free principal operators.

It was also found that the most promising indicator of the extra insurance risk was the minor moving traffic offences subject to demerit points. This included all speeding offences whether demerit points were awarded or not.

The data suggested that a more scientific system of conviction surcharges based on moving traffic violations would increase the fairness of the insurance system, producing lower premiums for the more careful 60% of drivers who avoid convictions as much as possible and higher premiums related to the higher risk of those drivers who tend to accumulate traffic convictions.

In the case of criminal code convictions, such as careless or impaired driving, refusing breathalyser, etc. and other types of conviction, an extra risk was indicated but such a small minority of drivers are involved in such offences that their contribution to the insurance pool by way of premium surcharges does not produce a noticeable reduction for other drivers."

“Further research is continuing into the following subject.

1. The significance of the timing of convictions, i.e. most recent year against three years old.
2. The significance by themselves of minor speeding convictions which do not qualify for demerit points.

The results at this stage should be used with caution since there may be some tendency for drivers in high mileage groups to have more convictions and the base rate for such groups may at present implicitly contain a margin for the extra risk.”

- The Committee is gratified that the concept of Drive-in Appraisal Centres is now well established in Ontario with 31 such centres now in operation. In this connection, the Committee is also pleased to note that the Insurance Bureau of Canada has adopted the Audatex automated appraisal system as suggested by the Committee in its First Report as a method of reducing repair costs.
- Appropriate changes have been made to legislation in order to eliminate the “gross negligence” test formerly required of a guest passenger when making a claim against his or her “host driver”.
- While the Committee had considered a proposal for the establishment of a self-regulating council for insurance agents and did not agree with it, legislation has been introduced to establish a self-regulating council for insurance brokers. In this context “brokers” as distinct from agents are free to write insurance for more than one company doing business in Ontario.
- In its First Report the Committee devoted considerable attention to the application form for automobile insurance, its clarification and simplification and a number of matters concerning its content. The Committee understands that the Superintendent of Insurance has established, together with industry representatives, a Forms Committee that is currently reviewing the application form in relation to all of the matters raised by the Committee.

Responses to the Committee’s Recommendations in the Third Report on General Insurance

The Committee’s Third Report on General Insurance was tabled in mid-1979. Since that time, steps have been taken by the Superintendent of Insurance and industry participants to implement certain of the Committee’s suggestions and recommendations. A number of other recommendations that were made by the Committee in its report are subject to on-going study by the Superintendent and the insurance industry with a view to determine the precise form of their implementation.

It is again impractical to comment on the disposition, current status and precise form of the implementation of the Committee's many recommendations that were included in its Third Report. Brief comments follow, however, concerning a few of the recommendations that were made by the Committee. These comments reflect the understanding which the Committee has obtained from the Superintendent and industry representatives that, with one exception, none of the Committee's recommendations have been considered, for the present, impossible to implement.

- In considering consumer expectation and needs regarding coverage on dwellings, the Committee concluded that full replacement cost coverage was a concept which the insurance industry as a whole should undertake to study and to offer without restriction in all homeowners' policies. Under this concept each policyholder would be insured to full replacement cost value on the dwelling, including debris removal, rather than to the amount of insurance coverage carried. The Committee suggested that an amount of insurance would be specified for premium setting purposes only.

This concept of full replacement cost which is not tied to an insured amount is considered by insurers as "unacceptable for underwriting reasons". They have indicated however they are encouraging all homeowners to provide for replacement costs at the same time insisting that this requires that policies be subject to the maintenance of insurance to value. Replacement costs coverage on contents is widely available.

- As a corollary to the industry's view concerning the importance of insuring to value, the industry has indicated that it is in complete agreement with the view expressed by the Committee that a reduced premium is better achieved through increased deductibles as a means of lowering the cost of insurance for the individual consumer and for the insurance system as a whole, with the elimination of minor claims.
- In keeping with the Committee's suggestion regarding the desirability of having available a choice of amounts of coverage for contents, the industry has responded by establishing special limits on special items, such as jewellery, furs, coin or other collections, designed to suit the average consumer.
- Throughout its report, the Committee supported the availability of greater choice in coverages, including the "unbundling" of package policies to permit the consumer to exercise a greater choice among the component coverage in the policy package. Insurers have taken steps to ensure that equivalent coverages can be bought separately but they continue to emphasize that the unbundling of a package undermines the savings built into the package concept.

- The Committee's suggestion to the industry to develop and offer without restriction a core coverage on dwellings that would meet the coverage expectations of the majority of consumers has been accepted by the industry and a standard form of such policy has been accepted by the Association of Superintendents of Insurance as a basic residential policy.
- The Committee encouraged the general insurance industry to develop and apply consistently a uniform cost evaluation process for determining the insurable value of properties and periodic inflationary factors used to update the calculation of insurable values. The Insurance Bureau of Canada, in response, has indicated that it has, through its Personal Lines Committee developed procedures for the constant review of a home evaluation program and that this program is proving its worth as demonstrated through the increased use of the program by insurers, agents and brokers.
- The Committee emphasized that the insurance industry must be sensitive to the consumer's needs for a simplified policy and it therefore recommended "that the re-writing of property and casualty policies be directed towards converting each policy to as simple and understandable a language as possible—that is, into "plain language". The industry should devote immediate attention to the redrafting of its personal lines policies and to the redrafting of the standard automobile policy as recommended in the First Report." The insurance industry has joined with the Superintendent in attempting to respond to this recommendation. The work of the various committees is not yet complete but both the Superintendent and industry representatives have indicated that they expect very shortly to complete the program which began in December, 1979.
- The Insurance Bureau of Canada (I.B.C.) has indicated that the Coverage Summary Page/Declaration Page has been revised to summarize clearly the coverages and limits in the policy and further that guidelines have been developed to assist consumers in reading and understanding their policy.
- In the context of the preceding comment, it is also understood that the industry, as part of its program of plain language communication, proposes to implement the Committee's suggestion of revising its pamphlets and brochures and other material provided to consumers so as to minimize any likelihood of misunderstanding by policyholders and prospective insurance buyers regarding the insurance product.
- The insurance industry has indicated that in the area of plain language communication it has been concentrating on its personal lines coverages. As regards the commercial area, the I.B.C. has indicated

that property insurers have provided simplified standardized policies for the small businessman, the retail store and for small offices. In the view of the I.B.C. it is preferable to allow these forms to be in existence for a little while before developing a commercial lines plain language policy. The Committees responsible within the I.B.C. have agreed that where standardization is possible it will be the rule.

- In response to the Committee's encouragement that the industry participate in a review of the classification system presently in use in its personal lines statistical plan, the I.B.C. has indicated that it is continuing to "constantly" review the plan and exhibits in order to reflect current environmental conditions, marketing considerations and other appropriate criteria in classifying risks. The Committee is pleased with the I.B.C.'s response in this regard to its recommendation but in so doing emphasizes the concern it expressed that some criteria may be used as surrogates for more appropriate criteria and that efforts should be made to make the classification system more understandable to the consumer.
- The I.B.C. have appointed a Consumer Liaison Officer at its head office to respond to questions raised by consumers. The I.B.C. has indicated that it is prepared to expand these services as its assessments of the situation indicate are warranted. The Committee acknowledges the actions taken by the Insurance Bureau of Canada in this regard as at least the first step in implementing its series of recommendations relating to the need within the general insurance industry for a focal consumer information and complaints service accessible to all residents and businesses.
- In order to attempt to utilize the insurance industry's total capacity, the Insurance Bureau of Canada has indicated that insurers have accelerated their efforts in the formulation of risk sharing associations such as Nuclear Insurance Association of Canada; Canadian Industry Risk Insurers; and Canadian Overseas Insurance Risk Association. Further, the industry has indicated that it is watching with interest the development of the New York Insurance Exchange for possible advantages and benefits from the point of view for a similar Canadian exchange.
- As has been noted previously, contrary to the view expressed by the Committee that the time was not propitious, legislation has been passed concerning the self-regulation of insurance brokers in Ontario. Many of the concerns regarding the agency system on which the Committee commented in its Third Report have as a result a slightly different focus now. The Committee is encouraged, however, that many of the matters it observed upon such as higher standards of qualifications for agents and brokers; one set of

educational or examination qualification requirements for agents and brokers; the role of insurance consultants and the related matter of fee for service are now all matters being addressed by the Registered Insurance Brokers of Ontario (RIBO).

- The concept of qualifying examinations and standards for brokers being set by industry peer groups subject to appropriate government control is in keeping with the Committee's recommendations.
- Included also with the establishment of self-regulation for insurance brokers in Ontario, RIBO has prepared a code of ethics for brokers. However, it is still too early to tell whether the procedures for enforcing the code are adequate.
- One matter closely related to the marketing of general insurance products through agents concerns the concept of the "take-all-comers" approach contemplated by the Committee. Representatives of the insurance industry and the Superintendent have indicated that committees are still looking at the "philosophy" of this concept.
- Another matter relating to the marketing of general insurance products concerns the Committee's encouragement that the general insurance industry develop group merchandising initiatives as forms of selling that reduce costs, so long as the group plans are carried out on sound bases that do not discriminate unfairly. The Superintendent and the insurance industry have responded to the Committee's recommendation and the Superintendent has recently issued mass merchandising guidelines covering automobile and property group plans subject to the limiting provisions of Section 363 of The Insurance Act.
- The Committee is pleased to note the continued support of the Insurance Bureau of Canada and individual companies in all aspects of loss prevention as indicated by their continuing communication program including such items as Arson Alert and the National Crime Test both of which will be shown to the public shortly.
- The Committee's recommendation that greater emphasis be placed on arbitration of disputes in the insurance system continues to be a matter being studied by industry committees and the Superintendent of Insurance.

Responses to the Recommendations in the Fourth Report on Life Insurance

The Committee's Fourth Report on life insurance was tabled in 1980 and as a consequence there has been little time for the Minister of Consumer and Corporate Affairs, the Superintendent and industry participants to develop detailed implementation programs in response to the Committee's recom-

mentations. Aside from a relatively few number of specific items the comments which follow merely reflect the approach being taken by those involved in implementing the Committee's recommendations during their necessary review and analyses as they develop their responses.

The Committee would like to make reference however to four particular matters regarding which specific responses have been taken.

- The Committee recommended that immediate attention be given to amending The Insurance Act in Ontario to include annuity contracts explicitly within the scope of the insurance business governed by the Act. The Committee is pleased to note that appropriate amendments have been made to ensure that the provisions of The Insurance Act which apply to life insurance apply uniformly to annuities.
- The Committee recommended that the licensing of life insurance agents by the Superintendent should be removed from The Insurance Act and replaced by the registration or recording of names of life insurance agents sponsored by life insurance companies with a statutory duty imposed upon insurers to keep the Agent Register records up-to-date. This recommendation is in the process of being implemented by the Ministry.
- The Committee had also recommended that sponsoring life insurers should be delegated responsibility in The Insurance Act for ensuring that its agents receive supervision, education and training appropriate to the agents' knowledge, experience and progress in the business. In response the Canadian Life and Health Insurance Association has developed a proposal that agent training, conduct and licensing be industry self-regulated and submitted a proposal for consideration by the Superintendents of Insurance of the Provinces at the Superintendents' Annual Conference in September 1980. This proposal which is still under review reads as follows:

“The Canadian Life Insurance Association is aware that Superintendents of Insurance in at least two or three provinces are actively considering withdrawing from licensing of Agents and are looking for recommendations on proposed industry involvement. A preliminary submission has very recently been made to the Superintendent of Insurance of Quebec proposing an industry licensing system for his province.

The Association believes that the life insurance companies have both the responsibility and the obligation to assume the licensing role should any Department of Insurance see fit to discontinue the present system.

Briefly, the Association would propose the forming of a new and separate organization, the “Life Insurance Licensing Board”, funded by the companies, which would assume responsibility for

new life insurance agent standards and licensing, plus annual re-licensing as required. Any life insurance company or organization requiring licensed agents would be eligible for membership.

Most provinces have common standards for licensing, and while we would hope to handle the bulk of administration from a central location, those provinces "opting-in" would retain the right to set provincial passing grades, etc. should that be desirable.

The "Licensing Board" would be provided with staff, offices and mechanical facilities, and would be responsible to a Board of Directors drawn from senior company officials. Provision could also be made for Board representation by representatives of the Superintendents of Insurance, and perhaps the Life Underwriters Association of Canada.

Many details remain to be worked out, but the Association's Board of Directors has firmly accepted the principle of responsibility for licensing wherever necessary."

- A matter beyond the recommendations made by the Committee is of particular interest as reflecting a possible trend in the operation of the business of insurance in the Province of Ontario. Specifically, a Committee on Self-Regulation within the Canadian Life and Health Insurance Association was formed following issuance of the Committee's Fourth Report and after the then Ontario Minister of Consumer and Corporate Affairs requested the life industry to develop plans over the next five years to provide self-regulation within the industry. At its first meeting earlier this year, the new committee concluded the following were the most essential elements of self-regulation:

- "1. The regulating body must be genuinely representative of the industry.
2. The regulating body must be actively supervised by the government.
3. The rules of the regulating body must be accessible and acceptable to the public. It is possible that the public could be involved to the extent of being represented on the self-regulatory body's government.
4. The regulating body must have a permanent staff providing competent administration.
5. The regulating body must be willing and able to discipline its members; the discipline must be effective and perhaps have several, progressive levels of severity; the ultimate discipline would be the withdrawal of a license to operate by either the self-regulatory body or the government (whichever bestows the

license in the first place); in any event enforcement will probably require government back-up.

6. There should probably be an appeal procedure respecting the disciplinary decisions.”

While it is impractical to comment further on the steps being taken to implement specific recommendations contained in the Committee’s Fourth Report, the Committee is gratified to learn of the manner in which the industry through its association have organized its review of the various matters raised by the Committee. The Canadian Life and Health Insurance Association has organized the Committee’s various recommendations into a number of sub-categories and then given to standing committees of the Association responsibility for reviewing, analyzing and responding to each recommendation. In this connection, the Association is liaising with the Superintendent on matters where there is joint or overlapping responsibility.

In this same context the Superintendent and his staff have organized their review of the various recommendations made by the Committee. They are reviewing under appropriate headings those matters where legislative changes would be necessary and then reviewing as a matter of separate concern those matters where the Committee had suggestions regarding the operations of the Office of the Superintendent.

The Committee is not aware that either the Superintendent or industry participants consider that any its suggestions or recommendations are impractical and impossible to implement.

E. THE ROLE OF THE SUPERINTENDENT

The Committee has commented throughout its reports on its concept of the authority and responsibility of the Superintendent of Insurance. Historically, the role of the Superintendent has emphasized his responsibility concerning the solvency of insurance companies with less attention being paid to other aspects of consumer protection. The Committee believes that it is important to bring a better balance to these two areas of responsibility. The Committee believes that the Superintendent of Insurance should take a more direct and visible stance regarding consumer protection in all fields of insurance. The Superintendent of Insurance for the Province of Ontario should be seen to be the consumer’s representative, recognizing that there are very few sophisticated enough to understand the intricacies of the business of insurance and that even the sophisticated in such matters have no effective means of enforcing improvements in the system when the need for improvements are identified.

The Committee expects the Superintendent to be the government’s representative in working with the participants in the insurance industry and to direct their collective efforts towards identifying and meeting consumer

needs. The emphasis should be on a broad definition of consumer needs and services balanced with a continuing emphasis on protection for the consumer by testing the financial solvency of insurers.

In keeping with its concept of minimum regulation of the business of insurance, the Committee envisages the Superintendent primarily as overseeing the way in which industry participants function in order to satisfy the consumer that lack of strict regulation does not result in practices contrary to the public interest.

APPENDICES

APPENDIX A

(referred to in the Preface)

LIST OF WITNESSES

A. MINISTRY OF CONSUMER AND COMMERCIAL RELATIONS, ONTARIO

Office of the Superintendent of Insurance in Ontario

Mr. M. A. Thompson, QC, Superintendent of Insurance
Mr. D. G. Triantis, Corporate Licensing
Mr. M. Crutcher, Chief Examiner, Insurance
Mr. R. Hendrie, Legal
Mr. B. D. Newton, Senior Actuary
Mr. F. Rahman, Actuary

B. INDUSTRY ORGANIZATIONS IN ONTARIO

The Canadian Association of Accident and Sickness Insurers

Mr. P. A. Burns, President of CASSI and Executive Vice-President of the Confederation Life Insurance Company
Mr. D. A. Post, Vice-President of CASSI
Mr. R. G. Mephram, Member of the Executive Committee of CASSI and Vice-President, Group, London Life Insurance Company
Mr. J. E. Stephens, Past President of CASSI and President and Chief Executive Officer of The Citadel General Assurance Company
Mr. R. E. Foster, Managing Director of CASSI
Mr. R. R. Rowlands, Executive Assistant of CASSI
Mr. K. G. Cook, Liaison Assistant of CASSI
Mr. D. J. Crawley, Senior Vice-President, Group Division, The Citadel General Assurance Company
Mr. J. M. Gill, Vice-President, Confederation Life Insurance Company

C. INDIVIDUAL INSURANCE COMPANIES SELLING ACCIDENT AND SICKNESS INSURANCE IN ONTARIO

Travelers Life Insurance Company of Canada

Mr. R. E. Nelson, FSA, Vice-President and Actuary, Individual
Mr. T. D. Philp, CLU, Vice-President, Group
Mr. A. E. Lapres, Assistant Vice-President
Mr. T. R. Diakun, ASA, Director, Individual
Mr. D. F. Douglas, Director, Group
Mr. R. J. Fitzpatrick, Director, Group
Mr. R. E. Smart, FSA, Actuary, Group

Mutual of Omaha Insurance Company

Mr. T. Child, Executive Vice-President
Mr. H. A. K. Brown, Vice-President, Administration
Mr. D. Spencer, Director of Travel
Mr. J. A. Johnston, Director of Product

Confederation Life Insurance Company

Mr. P. D. Burns, Executive Vice-President
Mr. J. B. Heard, Vice-President, Canadian Operations
Mr. B. W. Carpenter, Marketing Vice-President, Group Insurance
Mr. J. M. Gill, Administrative Vice-President, Group Insurance
Mr. K. A. J. Cuff, Superintendent of Agencies
Mr. T. B. Reynolds, Assistant Vice-President, Group Underwriting
Mr. G. W. Temple, Assistant Vice-President, Individual Insurance Administration
Mr. J. W. Topfer, Assistant Vice-President, Individual Underwriting

The Combined Insurance Company of America

Mr. R. K. Holmberg, Executive Vice-President
Mr. P. Cherian, Vice-President, Canada
Mr. G. H. Pugh, Vice-President and Director, Government Relations
Mr. N. Rocks, Vice-President, Administration, Canada
Mr. G. Buckingham, Assistant Vice-President, Canada
Mr. H. MacDonald, Executive Assistant, Canada

D. NON-PROFIT PREPAID MEDICAL CARE ORGANIZATIONS

Ontario Hospital Association—Ontario Blue Cross

Mr. R. A. Hay, Executive Director
Mr. B. A. Mead, Associate Executive Director, Blue Cross
Mr. P. L. Wood, Assistant Executive Director, Communication
Mr. R. J. Jackson, Assistant Executive Director, Pension and Group Life Services
Mr. G. J. Byrne, Assistant Executive Director, Blue Cross Administration
Mr. J. R. Cernik, Director of Fixed Income Investments, Investment Services
Dr. F. A. Evis, QC, Legislative Liaison Counsel
Mr. M. Flemming, QC, Counsel

Green Shield Prepaid Services Inc.

Mr. W. A. Wilkinson, Phm B, Chairman of the Board
Mr. W. H. Austen, RIA, President and Chief Executive Officer
Mr. R. R. Walker, QC, General Counsel
Mr. E. J. Laughlin, Regional Sales Manager, Central Ontario

Co-Operative Health Services of Ontario

Mr. Peter Clark, General Manager

Mr. Robert Kuenzig, Member

Canadian Union Mutual Benefit Association

Mr. D. M. Tripp, General Manager

Mr. J. Johnson, Attorney

**E. INDIVIDUALS AND ORGANIZATIONS IN ONTARIO
OTHER THAN ACCIDENT AND SICKNESS INSURANCE
INDUSTRY PARTICIPANTS AND NON-PROFIT
PREPAID MEDICAL CARE ORGANIZATIONS**

Edward P. Belobaba, Professor and Associate Dean, Osgoode Hall Law School, York University

The Canadian Council on Social Development

Mr. Patrick Johnston, Program Director, Social Services, Ottawa

Canadian Union of Public Employees

Ms. Lucie Nicholson, President, Ontario Division

Mr. R. Deaton, Assistant Director of Research

Mr. J. D. Fulton, Christian Science Committee on Publications for Ontario

Mr. T. J. Grady, Executive Director, Ontario Biofeedback Society, Stress Training, Research and Educational Services

Reuben A. Hasson, Professor of Law, Osgoode Hall Law School, York University

The Hudson's Bay Company

Mr. W. A. McColl, Manager, Pensions and Insurance

Mr. R. E. Nelson, FCIA, Vice-President and Actuary, Travelers Group

The Ontario Dental Association

Dr. G. E. Pitkin, Past President

Mr. J. C. Gillies, Executive Director

The Ontario Federation of Labour

Mr. Hugh Peacock, Legislative Director, Ontario Federation of Labour,
CLC

The Ontario Medical Association

Dr. R. D. Atkinson, Chairman

Dr. F. D. Fraser, Member

Dr. J. A. Saunders, Director of Health Services

Mr. R. G. Cooper, Secretary to Board

Ontario Risk and Insurance Management Society

Mr. R. S. Best of Dominion Foundries and Steel Limited (DOFASCO) and
President of Ontario Risk and Insurance Management Society

Mr. A. R. Cooke of Bata Limited and Member of the Working Committee

Mr. R. P. d'Andrade of Dominion Foundries and Steel Limited (DOFASCO)
and member of the Working Committee

Mr. R. M. Finn of The Corporation of the City of Toronto

Mr. R. M. Lunan of TransCanada Pipe Lines Limited

Mr. W. A. McColl of The Hudson's Bay Company

Mr. D. S. Piercey of Canadian Corporate Management Company Limited

The Ontario Safety League

Mr. S. F. Andrunyk, President and General Manager

The Prepaid Legal Services Program of Canada

Ms. D. Majury, Executive Director

Mr. R. Koskie, QC, Chairman

Professor Julio R. Menezes, Associate Professor, Faculty of Law, University
of Windsor

Ms. Elizabeth Sheehy, Osgoode Hall Law Society, York University

Mr. Gordon E. Smith, Fitness Ontario, Ministry of Culture and Recreation

Suncor Inc.

Ms. P. A. Dixon, Manager, Corporate Insurance

Mr. R. D. McCleary, Corporate Manager, Compensation

United Steelworkers of America

Mr. S. Cooke, Director, District 6

Mr. H. MacKenzie, National Office/Research Department

Mr. G. Barr, District 6 Office/Public Relations and Social Action

Mr. Robert Waterhouse, Coordinator, Rehabilitation Services

Mr. R. L. Whaley, FCIA, Vice-President and Actuary, Prudential Insurance Company

The Workmen's Compensation Board

The Honorable L. M. Alexander, QC, Chairman

Mr. R. Brewerton, Executive Director, Financial Services Division

Mr. W. R. Kerr, Executive Director, Claims Office

Dr. W. J. McCracken, Executive Director, Medical Services Division

Mr. J. Wisocky, Executive Director, Vocational Rehabilitation Division

Mr. W. Riddell, Solicitor

The Wyatt Company

Mr. R. A. Field, Vice-President

Mr. R. Nixon, Consultant

Mr. E. E. Brooker

APPENDIX B

(referred to in the Preface)

LIST OF EXHIBITS AND SELECTED REFERENCE MATERIAL

LIST OF EXHIBITS

Copies of the Exhibits are available in the Legislative Library, Main Parliament Building, Queen's Park, Toronto, Ontario.

1. Submission to Ontario Select Committee on Company Law from Canadian Association of Accident and Sickness Insurers.
2. Memorandum re Provincial Government Health Services from Canadian Association of Accident and Sickness Insurers.
3. 1980 World Congress of Rehabilitation International Winnipeg Canada June 22-27, 1980, Presentation by Ross R. Rowlands, Canadian Association of Accident and Sickness Insurers, Insurance-Rehabilitation Liaison Committee.
4. The Example of Section G physical risk appraisal by a member of the Canadian Association of Accident and Sickness Insurers.
5. Canadian Association of Accident and Sickness Insurers letter to members.
6. Presentation to the Select Committee on Company Law by the Superintendent of Insurance for the Province of Ontario.
7. Submission to Emmett M. of Hall, CC, QC, Special Commissioner from Canadian Association of Accident and Sickness Insurers.
8. Submission to the Ontario Select Committee on Company Law from Travelers Life Insurance Company of Canada.
9. Submission to Ontario Select Committee on Company Law on Travel and Blanket Insurance by Mutual of Omaha Insurance Company.
10. The Travelers Guide to the Ontario Health Insurance Plan, Ontario Ministry of Health.
11. Memorandum from Ministry of Consumer and Commercial Relations.
12. Ontario Select Committee on Company Law visit to Confederation Life Insurance Company.
13. Presentation by Combined Insurance Company of America to the Select Committee on Company Law.
14. Membership List as at July 1, 1980, Canadian Association of Accident and Sickness Insurers.

15. Accident and Sickness Insurance, an information pamphlet issued by Canadian Association of Accident and Sickness Insurers.
16. Submission to the Select Committee on Company Law regarding the operation of Ontario Blue Cross and Hospitals of Ontario, Disability Income Plan, by Ontario Hospital Association.
17. Extract from London Free Press, July 17, 1980, "Blue Cross Plan Provides for Extra Hospital Services".
18. Travelers of Canada: letter to Woods Gordon dated July 18, 1980 re: practices in setting premium rates for Group Accident and Sickness insurance.
19. Combined Insurance Company of America—Policies & Advertisements.
20. Presentation to the Select Committee on Company Law by CUMBA, July 23, 1980.
21. Green Shield Prepaid Services Inc. Brief to the Ontario Select Committee on Company Law (Windsor, Ontario).
22. Green Shield Prepaid Services Inc.—"Introduction. Who are We?"
23. Co-op Health Services Presentation to the Select Committee on Company Law, July 24, 1980.
24. Presentation on Benefits Insurance and the Insurance Industry to the Ontario Select Committee on Company Law, Thursday, July 24, 1980, 2:00 p.m.—Stewart Cooke, Director, District 6, United Steelworkers of America.
25. Preliminary Statement to the Ontario Select Committee on Company Law by the Ontario Division, Canadian Union of Public Employees concerning Comprehensive Disability Programs and Related Matters, July 29, 1980.
26. Submission by The Wyatt Company, July 29, 1980.
27. Wyatt "Viewpoint", November 1979 (Vol. 2, No. 5).
28. Submission from the Ontario Risk and Insurance Management Society ("ORIMS") July 30, 1980.
29. Submission by Hudson's Bay Company on Accident and Sickness Insurance, July 30, 1980.
30. Presentation to Ontario Select Committee on Company Law, by SUNCOR Inc., July 31, 1980, on Employee Compensation; and 2 Suncor packages of information pamphlets.
31. An Outline of Remarks to Ontario Select Committee on Company Law Hearings on Accident and Sickness Insurance, July 31, 1980—Products

Liability, Accident Compensation and Rational Law Reform—by Edward P. Belobaba.

32. A paper delivered to the Ninth Annual Conference on Commercial and Consumer Law, Faculty of Law, U. of T.: Nov. 3/79. Products Liability and Accident Compensation: A Social Insurance Perspective—Edward P. Belobaba.
33. Letter dated July 30, 1980 from Green Shield Prepaid Services Inc., Windsor (William A. Wilkinson, Chairman of the Board to James R. Breithaupt, re Drug Benefit prescriptions.
34. Submission to the Ontario Select Committee on Company Law by Prepaid Legal Services Program of Canada, Proposing Model Regulation for prepaid legal services in the form of a separate Prepaid Legal Services Act.
35. Two-page statement by James Cathro, London, Ontario, regarding “practice of the Insurance Companies of Canada to deduct from their Insurance payments. . . .”
36. Letter dated August 1, 1980, to Paul Boddy from Robin Wm. Noxon, The Wyatt Company, regarding copies of Field’s letter to Mr. M. Thompson and Thompson’s reply to Mr. Field.
37. Letter to Paul Boddy from Mr. W. A. Wilkinson, Chairman, Green Shield Prepaid Services Inc., dated July 24, 1980, regarding Brief of Prescription Services Inc. to the Royal Commission of Inquiry into the Confidentiality of Health Records in Ontario (dated April 20, 1978).
38. Submission by Reuben Hasson, Osgoode Hall Law School, York University, regarding “The Reform of Disability Insurance”.
39. Submission by Ms. Elizabeth Sheehy of York University regarding discrimination against women in accident and sickness insurance.
40. Submission to Ontario Select Committee on Company Law from R. E. Nelson, FCIA and R. L. Wahley, FCIA.
41. Submission by D. Fulton, Christian Science Committee on Publications for Ontario.
42. Press Clipping—“Saskatchewan plans universal insurance”—from Globe and Mail, August 25, 1980.
43. Submission by The Workmen’s Compensation Board, September 4, 1980.
44. Letter dated September 5, 1980, from Ralph Barrie, President, Ontario Federation of Agriculture, to Mr. J. Breithaupt, re: Co-op Health Services.

45. Brief to Select Committee on Company Law submitted by Ontario Medical Association, September 9, 1980.
46. Brief to the Royal Commission of Inquiry into the Confidentiality of Health Records in Ontario, submitted by Ontario Medical Association, April 1978.
47. Brief to the Commission on Freedom of Information and Individual Privacy, submitted by Ontario Medical Association, July 1977.
48. Presentation to Select Committee on Company Law by the Ontario Dental Association, September 9, 1980.
49. Report for the Ontario Select Committee on Company Law by the Provincial Co-ordinator of Rehabilitation.
50. Submission to the Ontario Select Committee on Company Law by The Ontario Safety League.
51. Supplementary submission to The Ontario Select Committee on Company Law by the Canadian Association of Accident and Sickness Insurers.
52. Notes for an address to The Ontario Select Committee on Company Law by Patrick Johnston, Program Director, The Canadian Council on Social Development.
53. A report to The Select Committee on Company Law regarding Physical Fitness and Life Style by Gordon E. Smith, Ministry of Culture and Recreation, September 18, 1980.
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- c) Booklets: *The Automated MIB* and *The History of the Automated MIB system*
- d) Statement regarding MIB's Security Program
- e) MIB "Request for Disclosure" (Form D2); sample letter of disclosure, sample disclosure instructions to reporting company; disclosure confirmation
- f) 1973 "Report on Examination of the Medical Information Bureau" by the New York State Insurance Department
- g) Sample correspondence and forms relating to MIB Company Visit ("Field Audit") Program
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APPENDIX C
(referred to in Chapter 6)

**LIFE AND GENERAL INSURANCE COMPANIES LICENSED
TO TRANSACT ACCIDENT INSURANCE,
SICKNESS INSURANCE AND ACCIDENT AND SICKNESS
INSURANCE IN ONTARIO, JULY 26, 1980**

Abbey Life Insurance Company of Canada	Abeille-Paix Reassurances
Abstainers' Insurance Company	Aeterna-Life Insurance Company
Aetna Casualty Company of Canada*	The Aetna Casualty and Surety Company*
Aetna Insurance Company*	Aetna Life Insurance Company*
The Albion Insurance Company of Canada	Alexander Hamilton Life Insurance Company of America
Alliance Mutual Life Insurance Company*	Allianz Insurance Company
Allstate Insurance Company	Allstate Insurance Company of Canada*
Allstate Life Insurance Company	Allstate Life Insurance Company of Canada
American Bankers Insurance Company of Florida	American Bankers Life Assurance Company of Florida
American Health and Life Insurance Company	American Home Assurance Company
The American Insurance Company	American Life Insurance Company
American Mutual Liability Insurance Company	American National Fire Insurance Company
American National Insurance Company	American Re-Insurance Company
Anglo Canada General Insurance Company	The Artisans, Life Insurance Cooperative Society
Assumption Mutual Life Insurance Company	L'Assurance—vie Desjardins
Atlantic Mutual Life Assurance Company*	Aviation & General Insurance Company Limited
Baltica-Skandinavia Insurance Company of Canada	Bankers Life and Casualty Company
Bankers Life Company	The Bay City General Insurance Company
The British Aviation Insurance Company, Limited	Business Men's Assurance Company of America

*Members of the Canadian Association of Accident and Sickness Insurers, July 1, 1980

The Canada Accident and Fire Assurance Company	Carolina Life and Accident Insurance Company
Canada Security Assurance Company	The Canada Life Assurance Company*
The Canadian Commerce Insurance Company	Canadian General Insurance Company
Canadian General Life Insurance Company*	The Canadian Indemnity Company
The Canadian Provincial Insurance Company	Canadian Reassurance Company
Canadian Reinsurance Company	The Canadian Surety Company
Canadian Universal Insurance Company Limited	The Capitol Life Insurance Company
The Casualty Company of Canada	Centennial Insurance Company
The Century Insurance Company of Canada	Charter National Life Insurance Company
Chateau Insurance Company	Chrysler Insurance Company
Chrysler Life Insurance Company of Canada	The Citadel General Assurance Company*
The Citadel Life Assurance Company*	College Retirement Equities Fund
Cologne Life Reinsurance Company	Colonia Life Insurance Company
Combined Insurance Company of America*	Commerce and Industry Insurance Company of Canada
The Commerce Group Insurance Company	The Commercial Life Assurance Company of Canada
Commercial Travelers Mutual Insurance Company*	Commercial Union Assurance Company of Canada
Commercial Union Assurance Company, Limited	Commonwealth Insurance Company
Chubb Insurance Company of Canada	Confederation Life Insurance Company*
Constellation Assurance Company*	Connecticut General Life Insurance Company*
Continental Assurance Company	Constitution Insurance Company of Canada*
The Continental Insurance Company*	Continental Casualty Company
The Continental Insurance Company of Canada	The Contingency Insurance Company Limited
Colonial Life and Accident Insurance Company	Co-Operative Fire and Casualty Company*
Co-Operators Life Insurance Association	Co-Operators Insurance Association

Coronation Insurance Company,
 Limited
 Crown Life Insurance Company*

 Cuna Mutual Insurance Society*
 Cumis Insurance Society, Inc.*

 The Dominion Insurance
 Corporation*
 The Dominion of Canada General
 Insurance Company

 Eagle Star Insurance Company
 Limited
 Eaton/Bay Life Assurance
 Company
 Economical Mutual Insurance
 Company
 Elite Insurance Company

 The Empire Life Insurance
 Company*
 The Equitable Life Assurance
 Society of the United States*
 The Excelsior Life Insurance
 Company*

 Federal Insurance Company
 Federated Mutual Insurance
 Company
 Fidelity Life Assurance Company

 Fireman's Fund Insurance
 Company
 Fireman's Fund Insurance
 Company of Canada
 Ford Life Insurance Company

 Foresters Indemnity Company

 The General Accident Assurance
 Company of Canada
 General Reassurance Corporation
 General Security Insurance
 Company of Canada

Cornhill Insurance Company,
 Limited
 The Credit Life Insurance
 Company
 Cumis Life Insurance Company*

 The Dominion Life Assurance
 Company*

 Eaton/Bay Insurance Company

 L'Economic Mutuelle
 d'Assurance*
 Emmco Insurance Company

 Employers Insurance of Wasau A
 Mutual Company
 Employers Reinsurance
 Corporation
 The Equitable Life Insurance
 Company of Canada*

 Federal Home Life Insurance
 Federated Life Insurance
 Company
 Fidelity Insurance Company of
 Canada*
 Financial Life Assurance
 Company of Canada
 Fireman's Fund American Life
 Insurance Company
 Foremost Insurance Company,
 Grand Rapids, Michigan
 The Franklin Life Insurance
 Company

 General American Life Insurance
 Company
 General Reinsurance Corporation
 Gerling Global General Insurance
 Company

Gerling Global Life Insurance
Company
Gibraltar General Insurance
Company
Globe Life Insurance Company
Gore Mutual Insurance Company

The Great Eastern Insurance
Company
The Great-West Life Assurance
Company*
Guardian Insurance Company of
Canada*

The Halifax Insurance Company
The Hartford Fire Insurance
Company
Herald Insurance Company

Highlands Insurance Company

The Imperial Life Assurance
Company of Canada*
INA Life Insurance of Canada

Industrial Life Insurance-
Company*
Insurance Company of North
America

John Alden Life Insurance
Company

Kanata Reinsurance Company

The Laurentian Mutual Assurance
Company*
Liberty Mutual Fire Insurance
Company
Life Insurance Company of North
America
The Lincoln National Life
Insurance Company
London-Canada Insurance
Company

Gerling Global Reinsurance
Company
Glacier National Life Assurance
Company
Gold Circle Insurance Company
Great American Insurance
Company
The Great Lakes Reinsurance
Company
The Guarantee Company of North
America

The Hanover Insurance Company
Hartford Life Insurance Company

Heritage Life Assurance
Company*
The Home Insurance Company

INA Insurance Company of
Canada
Independence Life and Accident
Insurance Company
Insmor Mortgage Insurance
Company

John Hancock Mutual Life
Insurance Company*

Laurier Life Insurance Company*

Liberty Mutual Insurance
Company
Life Investors Insurance Company
of America
The London Assurance

London Life Insurance Company*

London and Midland General
Insurance Company
Lumbermens Mutual Casualty
Company

Maccabees Mutual Life Insurance
Company

Maplex General Insurance
Company

Markel Insurance Company of
Canada*

Massachusetts Indemnity and Life
Insurance Company*

Massachusetts Mutual Life
Insurance Company*

The Mercantile and General
Reinsurance Company Limited*

Midland Insurance Company

The Minnesota Mutual Life
Insurance Company

The Monarch Life Assurance
Company*

MONY Life Insurance Company
of Canada*

Munich Reinsurance Company of
Canada

The Mutual Life Insurance
Company of New York

Mutuelle Generale Francaise
Accidents

National Fidelity Life Insurance
Company

The National Reinsurance
Company of Canada

Netherlands Reinsurance Group
N.V.

New Hampshire Insurance
Company

New York Life Insurance
Company*

North American Company for
Property and Casualty Insurance

Loyal Protective Life Insurance
Company

The Manufacturers Life Insurance
Company

The Maritime Life Assurance
Company*

Maryland Casualty Company

Massachusetts General Life
Insurance Company

The Mercantile and General
Reinsurance Company of
Canada*

Metropolitan Life Insurance
Company*

The Ministers Life and Casualty
Union

The Missiquoi and Rouville
Insurance Company

Montreal Life Insurance
Company*

Munich Reinsurance Company*

The Mutual Life Assurance
Company Canada*

Mutual of Omaha Insurance
Company*

The National Life Assurance
Company of Canada

Nationwide Mutual Insurance
Company

New England Mutual Life
Insurance Company

The New India Assurance
Company Limited

Niagara Fire Insurance Company*

North American Life Assurance
Company

North American Life and Casualty
Company
North American Reinsurance
Corporation
Northern Union Insurance
Company Limited
The North West Life Assurance
Company of Canada

Occidental Life Insurance
Company of California*
Old Republic Life Insurance
Company*
Ontario Motorist Insurance
Company
The Orion Insurance Company,
Limited

Pacific Employers Insurance
Company
La Paix General Insurance
Company of Canada
The Paul Revere Life Insurance
Company*
Pennsylvania Life Insurance
Company*
Perth Insurance Company
Phoenix Assurance Company,
Limited
The Phoenix Insurance Company
(Hartford, Conn.)
Pilot Insurance Company*
Pitts Life Insurance Company*
The Portage la Prairie Mutual
Insurance Company
La Preservatriee Societe Anonyme
d'Assurance Contre les Accidents
l'Incondie et les Risoues Divers
Pan American Family Insurance
Corporation
The Prudential Assurance
Company Limited*
The Provident Assurance
Company
Prudential Reinsurance Company*

North American Reassurance
Company
The Northern Life Assurance
Company of Canada*
Northumberland General
Insurance Company
Norwich Winterhur Reinsurance
Corporation Limited

Old-Republic Insurance
Company*
The Omaha Indemnity Company

Ontario Mutual General Insurance
Company
Otter Dorechester Mutual
Insurance Company

Pafco Insurance Company,
Limited
The Patriot Life Insurance
Company
The Penn Mutual Life Insurance
Company
The Personal Insurance Company
of Canada
PHF Life Insurance Company
Phoenix Assurance Company of
Canada
Phoenix Mutual Life Insurance
Company
Pitts Insurance Company
Pohjolda Insurance Company Ltd.
Les Prevoyants du Canada

Providence Washington Insurance
Company

Provident Alliance Life Insurance
Company
Provident Life and Accident
Insurance Company*
The Prudential Insurance
Company of America*

QBE Insurance Limited

The Reinsurance Corporation of
New York

Reliance Insurance Company

Safeco Life Insurance Company

SCOR Reinsurance Company of
Canada

Scottish & York Insurance Co.
Limited

Seaboard Life Insurance
Company*

Security National Insurance
Company

Societe Commerciale de
Reassurance

The Sovereign Life Assurance
Company of Canada

State Farm Fire and Casualty
Company

State Mutual Life Assurance
Company of America

State Farm Mutual Automobile
Insurance

Storebrand International
Reinsurance Company Ltd.

Sun Alliance Insurance Company

Symons General Insurance
Company

Teachers Insurance and Annuity
Association of America

Toronto General Insurance
Company

Traders General Insurance
Company

Travelers Indemnity Company of
Canada*

Truck Insurance Exchange

Quebec Assurance Company

Reliable Life Insurance Company*

Royal Insurance Company of
Canada

The Safeguard Life Assurance
Company

St. Paul Fire and Marine Insurance
Company

Security Mutual Casualty
Company

Simcoe & Erie General Insurance
Company

The Sovereign General Insurance
Company

Societe Anonyme Francaise de
Reassurances

Sphere Reinsurance Company of
Canada

The Standard Life Assurance
Company

The Standstead & Sherbrooke
Insurance Company

Stonewall Insurance Company

Sun Life Assurance Company of
Canada*

Swiss Reinsurance Company

The Tokio Marine and Fire
Insurance Company Limited

The Travelers Indemnity
Company*

The Travelers Insurance
Company*

Travelers Life Insurance Company
of Canada*

Underwriters National Assurance
Company
Union Mutual Life Insurance
Company
Unione Italiana di Riassicurazione
S.p.A.
United Benefit Life Insurance
Company
The United Provinces Insurance
Company
United States Fire Insurance
Company
The Unity Fire and General
Insurance Company

The Victory Insurance Company,
Limited*

Washington National Insurance
Company
Wawanesa Mutual Insurance
Company
The Western Assurance Company

York Fire & Casualty Insurance
Company

Zurich Insurance Company*

United American Insurance
Company
United Canada Insurance
Company
United States Fidelity and
Guaranty Company*
Upper Canada Insurance Company

Utica Mutual Insurance Company

Unigard Mutual Insurance
Company

The Waterloo Mutual Insurance
Company
The Wawanesa Mutual Life
Insurance Company
The Western Life Assurance
Company*

Zurich Life Insurance Company of
Canada*

APPENDIX D
(referred to Chapter 6)

**FRATERNAL SOCIETIES LICENSED IN ONTARIO,
JULY 26, 1980**

Actra Fraternal Benefit Society	The Associated Canadian Travellers
Canadian Foresters Life Insurance Society	Canadian Slovak Benefit Society
Croatian Catholic Union of U.S.A.	The Canadian Woodmen of the World
Croatian Fraternal Union of America	
The Hungarian Reformed Federation of America	
The Independent Order of Foresters*	
Labour Zionist Alliance	Lutheran Life Insurance Society of Canada*
National Fraternal Society of the Deaf	
The Ontario Secondary School Teachers' Sick Benefit Society	The Order of Italo-Canadians
The Royal Arcanum, Supreme Council of	
Serb National Federation	Sons of Scotland Benevolent Association
Ukrainian Mutual Benefit Association on St. Nicholas of Canada	Ukrainian Fraternal Society of Canada
Ukrainian National Association, Inc.	Union of Canada Life Insurance United Commercial Travelers of America Order of
Workers Benevolent Association of Canada	The Workmen's Circle

*Members of the Canadian Association of Accident and Sickness Insurers, July 1, 1980

APPENDIX E
(referred to in Chapter 6)

**MUTUAL BENEFIT SOCIETIES LICENSED IN ONTARIO,
JULY 26, 1980**

Army and Navy Veterans Society
of Hamilton

Bled Mutual Benefit Society

Brantford Hungarian Mutual
Benefits Society

Canadian Hebrew Benevolent
Society
Czenstochower Aid Society

Driltzer Young Men's Mutual
Benefit Society

Goodwill Mutual Benefit Society

Hamilton St. Stanislaus Mutual
Benefit Society

Independent Friendly Workers
Circle Mutual Benefit Society
Italian Mutual Benefit Society of
Port Colborne and Humberstone
Iwansker Mutual Benefit Society

Judean Benevolent and Friendly
Society

Kieltzer Sick Benefit Society of
Toronto

Lagover Mutual Benefit Society
Lodzer Centre Mutual Benefit
Society

Border Cities Italian Club Mutual
Benefit Society

Brantford Polish Mutual Benefits
& Friendly

Canadian Pacific Expressmen's
Sick Benefit Association

Grand Order of Israel Benefit
Society

The Hebrew Friendly Sons of
David Mutual Benefit Society

Independent Mutual Benefit
Federation

Italian Ladies' Mutual Benefit
Society of Hamilton

Italian Mutual Benefit Society of
Port Arthur

Linitzer Sick Benefit Society

Maclean-Hunter Printing Division
Mutual Benefit Society
Massey-Harris Company Verity
Works Sick and Funeral Mutual
Benefit Association

Odd Fellow, Grand Lodge of
Ontario
Ostrowetz Independent Mutual
Benefit Society

Polish Alliance Friendly Society
of Canada
Pride of Israel Sick Benefit
Society

Randomer Mutual Benefit Society

Societa Figli d'Italia di Mutuo
Soccorso St. Antonio di Ottawa
St. Boniface Benefit Society
Stashiver Young Men's Mutual
Benefit Society

Toronto Grand Order of Israel
Mutual Benefit Society
Toronto Independent Benevolent
Association

United Jewish People's Order
Mutual Benefit Society

Vitese Mutual Benefit Society

Warsaw Lodzer Mutual Benefit
Association

Young Men's Hebrew Association

Zion Benevolent Society

The Marconi Mutual Benefit
Society of Hamilton
Moziere Sick Benefit Society

Order of Sons of Italy of Ontario
Mutual Benefit Society
Ozrower Mutual Benefit Society

Polish National Union of Canada
Mutual Benefit Society

Societa Italiana di Mutuo
Soccorso Guglielmo Marconi
Sons of Jacob Benevolent Society
St. Joseph Aid Society of Formosa

Toronto Hebrew Benevolent
Society

Wierzbniaker Friendly Mutual
Benefit Society

APPENDIX F

(referred to in Chapter 12)

CODE OF ETHICS OF THE CANADIAN ASSOCIATION OF ACCIDENT AND SICKNESS INSURERS

The underwriting and sale of voluntary accident and sickness insurance is in the public interest. To encourage maintenance of the highest standards of protection and service and to sustain public confidence in the business of voluntary accident and sickness insurance, the Canadian Association of Accident and Sickness Insurers has adopted this Code of Ethics. Acceptance of its principles and compliance with its provisions is a condition of membership in this Association. *Each member insurer undertakes henceforth:*

1. To offer only insurance providing effective and real protection against such loss as the policy is designed to cover.
2. To keep to practical limits the policy forms used by the insurer, and to ensure that the variety of forms used do not reflect more inconsequential differences in coverage.
3. To write its policies in clear, direct and unambiguous language without unreasonable restrictions and limitations, providing a clear expression of the insurer's undertaking.
4. To ensure that the insurer agreements when read with exclusions and conditions constitute an expressed promise to pay within limits of insurer's intended undertaking; and to give prominence to exclusions to assure their recognition.
5. To treat policies providing benefits against special or unusual risks for exposures of rare occurrence as justified *only* when such protection is for a special circumstance of an insurable nature or is supplemental to other insurance programs.
6. To use the term "limited policies" to refer to policies providing coverage *only* within a specified field and to express clearly the field covered. Also, to state clearly on the face and filing back of the policy that it is a limited policy, and to ensure that the aggregate of the hazard covered should be of sufficiently frequent occurrence to justify the sale of the policy.
7. To use only policy names, titles or symbols which are not such as to give a misleading impression of the coverage.

8. Where an accident policy provides indemnities of varying amounts for the same loss for injury sustained in different types of accidents (which policy is said to provide “multiple indemnities”), to provide multiple indemnities for loss resulting from injuries occurring in other than ordinary accidents only where the field in which such special injuries occur is well defined and clearly stated. If a policy provides different conditions, not to give the larger amount more prominence than the smaller amount.
9. To write insurance only when it is in the public interest, recognizing that in the case of group insurance although each situation should be viewed on its own merits, and exceptions can occur, it is normally *not* in the public interest to write such insurance under the following circumstances:
 - (a) where the amount of insurance or the degree of contingency insured against is so trivial, or the duration of insurance is so short, that the insurance is essentially without value; and
 - (b) where the method of presentation, including advertising, is such as to be misleading about the nature of the benefits.
10. To underwrite association groups, and other groups where an employer-employee relationship is not directly involved, with particular care to avoid conditions which may be inimical to the best interest of the public, recognizing particularly that it is normally *not* in the public interest to write insurance where the permanence of the insurance plan, and the maintenance of satisfactory underwriting results cannot be assured.
11. As to the use of the terms “non-cancellable” and “guaranteed renewable”,
 - (a) to use the terms “non-cancellable” or “non-cancellable and guaranteed renewable” only in a policy which the insured has the right to continue in force by the timely payment of premium set forth in the policy
 - (i) until at least age fifty, or
 - (ii) in the case of a policy issued after age forty-four, for at least five years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force;
 - (b) except as provided in (a) above, to use the term “guaranteed renewable” only in a policy which the insured has the right to continue in force by the timely payment of premiums
 - (i) until at least age fifty, or
 - (ii) in the case of a policy issued after age forty-four, for at least five years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force except that the insurer may make changes in premium rates by classes;

(c) to follow the rule that the foregoing limitation on use of the term “non-cancellable” shall also apply to any synonymous terms such as “not cancellable” and the limitation on use of the term “guaranteed renewable” shall apply to any synonymous terms such as “guaranteed continuable”;

(d) in any policy in which the term “non-cancellable” or the term “guaranteed renewable” is used, to couple that term in the same size type with the term for which it is in fact non-cancellable or guaranteed renewable;

provided that the above rules are not intended to restrict the development of policies having other guarantees of renewability or to prevent the accurate description of their terms of renewability, provided the terms used to describe them in the policy contracts and advertising are not such as may be readily confused with the above terms.

12. To underwrite “confinement” as used in relation to a contract of personal accident and/or sickness insurance—other than hospital confinement—as a separate risk.

Where a contract of personal accident and/or sickness insurance includes as one of the separate risks for which coverage is provided by contract, the risk of confinement, specifically to state in the contract the circumstances under which the insured ceases to be entitled to confinement benefits.

Not to use confinement as a measure of “disability” for the purposes of determining the entitlement of the insured to benefits under the contract.

13. Not to use a method of presentation, including advertising, which is such as to be misleading about the nature of the benefits; specifically not to describe insurance as “free”.
14. To advertise its policies in such manner that the public can readily understand the protection offered, and not use advertising which would mislead or confuse a prospective purchaser.
15. To select, train, and supervise personnel of integrity in a manner which will assure intelligent, honest, courteous sales and service.
16. To engage only in sales methods, promotional practices and other transactions which give primary consideration to the needs, interest, and continued satisfaction of the persons insured.
17. To endeavor to establish the insurability of persons at the time of application in every instance where such insurability is a factor in the issuance or continuance of the insurance or in the liability of the insurer, except in the case of a policy where wording is included in the contract to indicate any time period following the effective date of the policy during which losses attributable to pre-existing conditions are not covered.

18. To pay all just claims fairly, courteously, and promptly, with a minimum of requirements.
19. To continue research and experimentation in order to meet the changing needs of the public.
20. To engage in keen, fair competition so the public may obtain the protection it needs at a reasonable price.

APPENDIX G

(referred to in Chapter 13)

SUMMARY OF GUIDELINES IN FORCE OR PROPOSED CONCERNING ACCIDENT AND SICKNESS INSURANCE

- A. Guideline Respecting Mass Advertising of Life, Accident and Sickness Insurance Effective May 15, 1973
- B. Guidelines Covering Group Accident Insurance and Group Sickness Insurance Effective January 1, 1976
- C. Guidelines for Disclosure Relative to Accident Insurance and Sickness Insurance Effective July 1, 1976
- D. Guidelines for the Disclosure of Benefits, Limitations and Exclusions in Individual Policies of Accident and Sickness Insurance Effective January 1, 1978
- E. Proposed Guideline for Disclosure on Group and Creditors Group Accident and Sickness Insurance
- F. Proposed Guideline Governing Credit Card Group Accident and Sickness Insurance

A. GUIDELINE RESPECTING MASS ADVERTISING OF LIFE, ACCIDENT AND SICKNESS INSURANCE EFFECTIVE MAY 15, 1973

1. Purpose:

The purpose of this Guideline is to assure truthful and adequate disclosure in all advertisements and related literature used in the mass solicitation of life, accident and sickness insurance. It is intended that this purpose be accomplished by the establishment of, and adherence to, certain minimum standards of conduct in the mass advertising of life, accident and sickness insurance in a manner which avoids unfair competition among insurers and is conducive to the accurate presentation and description to the public of such insurance offered through various mass advertising media.

2. Application:

This Guideline is directed to the use of "coupon" advertisements in newspapers, magazines, direct mail or brochures on counters, that constitute a direct invitation to contract for life or accident and sickness insurance.

For the purpose of this Guideline, such “coupon” advertisements include:

- (a) a direct or principal sales inducement designed to invite the public to contract with the facility to contract, by the inclusion of an application for insurance for the issue of an individual contract to the applicant
- (b) a broad description of coverage designed to invite the public to request an application for insurance with additional printed material by way of explanation for the purpose of issuing an individual contract of insurance to the applicant.

In such instances, the advertisement is an essential part of the understanding by the public of what the insurance provides. It must be recognized that all exceptions, reductions and limitations of coverage must be clearly set forth and disclosed.

3. Specific Interpretation:

- (a) For the purpose of this Guideline, an advertisement shall include:
 - (i) printed and published material and descriptive literature of an insurer used in newspapers, magazines, and radio and T.V. scripts in conjunction therewith;
 - (ii) illustrations, circulars, memoranda, booklets and form letters of all kinds including related outgoing and business-reply envelopes or cards mailed by an insurer, without solicitation, on a mass solicitation basis, to members of the public; and
 - (iii) brochures, pamphlets and other printed literature displayed by an insurer or agent on store counters, booths and other public places for purposes of information or distribution to members of the public.
- (b) All such advertisements, regardless by whom written, created, designed or presented, shall be the primary responsibility of the insurer whose name and policies are so advertised.
- (c) This Guideline shall also apply to agents and brokers to the extent only that they are responsible for the advertisement of any individual policy.
- (d) This Guideline shall not apply to variable or equity-linked contracts of life insurance and information folders pertaining thereto within the meaning of The Insurance Act and Regulation thereunder.

4. Advertisements in General:

- (a) Advertisements shall be truthful and not misleading in fact or in implication.

- (b) As a general principle, words or phrases which are commonly understood by the public with respect to insurance, for example, such words or phrases as premiums, policies, contracts, cancellation, reinstatement, grace period, capital, assets, investments, insured, policyholders, insurance company and insurance, usually need not be further qualified in the context of the advertisement. However, certain words or phrases, unless adequately clarified in the context of the advertisement, may mislead those who are not familiar with insurance terminology. For example, terms such as “cash value”, “cash surrender value” and “loan value”, should not be used unless such terms are clearly defined in the advertisement.
 - (c) Advertisements shall not contain statements that the policy advertised is a “low cost plan” because no insurance agent is involved in the sale of the policy and no commission is payable when, in fact, the expense of advertising and servicing such policies forms a substantial cost factor in the marketing of policies so advertised.
 - (d) Terms which normally connote variable or equity-linked life insurance contracts, such as “growth” or “growth life” may not be used in advertisements to which this Guideline applies.
5. Advertisements of Benefits Payable, Losses Covered or Premiums Payable:
- (a) Deceptive words, phrases or illustrations:

Words, phrases or illustrations shall not be used in a manner which misleads, is incomplete, or has the capacity and tendency to deceive as to the extent of any policy benefit payable, loss covered or premium payable.
 - (b) Exceptions, Reductions and Limitations:
 - (i) When an advertisement refers to dollar amount, period of time for which any benefit is payable, cost of policy or specific policy benefit, or the loss for which such benefit is payable, it shall also clearly disclose in conjunction therewith, and in close proximity thereto, in equally prominent print, those exceptions, reductions, exclusions, and limitations that affect the basic provisions and intent of the policy.
 - (ii) Any exception, reduction or limitation in a policy shall not be worded in a positive manner to imply that it is a benefit; for example, statements such as “even pre-existing conditions are covered after two years”, shall be avoided.
 - (iii) Any such exception, reduction or limitation as to a benefit under the policy shall be printed with typeface at least as large and prominent as the typeface which states the benefit.

(c) Premium Change:

Where a premium is subject to change, the advertisement shall state clearly the circumstances and manner of the change.

In particular, the date of commencement and the period of time for which any benefit is payable under the policy, and particulars in dollar amounts of any scheduled changes in premium rates after the first or initial premium payable for the coverage, shall be clearly set out in the advertisement.

6. Exaggerated Statements:

For the purpose of this Guideline, an insurer shall not in any advertisement exaggerate the extent of policy benefits or minimize costs by using phraseology which either overstates benefits, or is so incomplete that the reader might normally be left with an exaggerated impression of the benefits described.

7. Benefits Supplemental to Provincial Medicare Plans:

- (a) Advertising of policies which are specifically tailored to supplement benefits available under Provincial medicare plans shall disclose clearly benefits the policy is designed to supplement, for example, hospital benefits only and benefits it will not supplement.
- (b) Advertisements shall not emphasize the total amounts payable under hospital indemnity coverage or other benefits in such policy, such as benefits for private duty nursing, unless it provides with substantially equal prominence and in close conjunction with such statements, the restrictions or limitations on the amounts payable for such indemnity or benefit.
- (c) In particular, advertisement of such hospital or medical benefits, payment of which is conditional upon confinement, shall not contain statements implying that the benefit is payable on a monthly or weekly basis only when, in fact, the amount of the benefit payable is determined on a daily pro rata basis related to the number of days of confinement.
- (d) Where payment of such hospital or other benefits is conditional upon confinement in a hospital or similar facility, there should not be used in the advertisement with respect thereto words or phrases such as "tax free", "extra cash", "extra income", "extra pay", or words or phrases of similar import which have the capacity and tendency to deceive or mislead the public into believing that the policy advertised will enable some profit to be derived from hospitalization.
- (e) Advertisements of hospital or medical or disability benefits shall not contain statements that the prospect requires or needs the coverage offered therein but can state the reason why the prospect may need or want such coverage.

8. Immediate Coverage or Guaranteed Issuance of a Policy:

Any solicitation which states or implies immediate coverage or guaranteed issuance of a policy shall be made only if the insurer has suitable administrative facilities so that the policy can be issued or immediate coverage otherwise documented within a reasonable time after the application is received.

9. Medical Examination and Pre-Existing Conditions:

(a) The phrase “no medical examination required” or a phrase of similar import shall not be used unless:

(i) the phrase is qualified to indicate that it applies only to the issuance of a policy or to both issuance of the policy and payment, of claims, whichever the case may be (for example, “no medical examination required to apply”, “no medical examination to apply for the policy or any benefits”) and

(ii) additional wording is included in close conjunction with the phrase to indicate any time period following the effective date of the policy during which losses attributable to pre-existing conditions are not covered during the first _____ years the policy is in force.

(b) Advertisements shall further disclose the exceptions, reductions, and limitations that affect the basic provisions of the policy without which the advertisement would, or might have, the capacity and tendency to mislead, confuse, or deceive. For example, an exclusion or reduction for loss due to pre-existing physical impairment shall be disclosed clearly in the advertisement, as shall the fact that loss due to certain illnesses or physical conditions is not covered or will result in a reduction of benefits, if such is the case.

10. Renewability, Cancellability, Termination and Modification of Policy Benefits:

(a) An advertisement which refers to renewability, cancellability, or termination of a policy, shall disclose the provisions relating to renewability, cancellability and termination in such manner as shall not understate or render obscure the qualifying conditions.

(b) An advertisement which refers to a policy benefit, or which states or illustrates time or age in connection with eligibility of applicants or continuation of the policy, shall disclose any modification of benefits, losses covered or premiums because of age or for other reasons, in such manner as shall not understate or render obscure the qualifying conditions.

11. Testimonials:

All testimonials used in advertisements shall be genuine and must not be fictitious. They must be accurate and precise and represent the reasonably

current opinion of the author. They should be restricted and confined to testimonials of a general nature or character wherein the author may state that he or she has knowledge of the insurer presenting the offering, is aware of its present offering to the public, is grateful for prompt and courteous treatment received in the past, and its reputation for prompt payment of claims, and may then invite the prospect or reader to consider the current offerings, and come to his own conclusion as to the benefits thereof. Where a testimonial or a recommendation is paid for directly or indirectly by the insurer, or on its behalf by anyone else, the advertisement shall so state. In using a testimonial, the insurer shall be deemed to assume as its own all of the statements contained therein and the advertisement including such statements is subject to all of the provisions of this Guideline.

12. Use of Statistics:

- (a) An advertisement referring to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not be used in any way that is misleading in respect to such information.
- (b) The source of any statistics used in an advertisement shall be clearly identified in such advertisement.

13. Free Inspection of Policy or Premium Refund:

An offer in an advertisement of free inspection of the policy or offer of a premium refund shall not in any way avoid compliance with the requirements of this Guideline.

14. Unfair and Disparaging Comparisons:

An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits, or otherwise falsely disparage the policies, services or business methods of competitors.

15. Identity of Insurer:

An advertisement shall properly identify the insurer concerned and shall not use a trade name, service mark, slogan, symbol, or other device which has the capacity and tendency to mislead or deceive as to the true identity of the insurer. However the insurer is identified in the advertisement, its full corporate name shall be prominently shown on the accompanying application for insurance.

16. Introductory, Initial or Special Offers:

- (a) An advertisement shall not state or imply that a particular policy or combination of policies is an introductory, initial, or special offer and that the applicant will receive advantages by accepting the offer, or that the offer is limited to a specified group of individuals, unless such is the fact.

- (b) An advertisement shall be so designed and worded that from any reference to premiums a prospect will be able readily to determine from the advertisements the amount of the premium and any subsequent premiums. No special introductory premium, however, shall be offered in an advertisement, other than an actuarially sound preliminary term premium. An insurer may, however, provide coverage prior to the due date of the first premium.
- (c) An advertisement shall not contain any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, or that an individual will receive special advantages by enrolling within an open enrollment period or by a deadline date, unless such is the fact.

17. Settlement of Claims:

An advertisement shall not contain misleading statements with respect to the time within which claims are paid or statements which imply that claim settlements will be liberal or generous beyond the terms of the policy.

18. Financial and Other Status of Insurer:

- (a) Any statement in an advertisement relating to the insurer's assets, corporate structure, financial standing, age or relative position in the insurance industry shall be factually correct.
- (b) An advertisement shall not contain statements, words, phrases, symbols or other features which create or tend to create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims or the merits, desirability or advisability of its policy forms or plans of insurance, or the advertisement, are approved or endorsed by any division or agency of a Provincial government.

19. Disclosure in General and Listing of Qualifications, etc.:

- (a) All information required to be disclosed shall be set out conspicuously and in close conjunction with the statements to which the information relates, or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.
- (b) The purpose is to ensure that all information will be disclosed under one of the alternative methods in the preceding paragraph in such a manner that the arrangement of the material itself will not have the capacity and tendency to confuse or mislead.
- (c) In particular, and without prejudice to the generality of the preceding paragraphs, every advertisement describing the particular benefits of

a policy shall include in the first page, or if the advertisement is contained in a single page, prominently at or near the top of that page, in print as large as any other print used therein, under the heading of "Qualifications, Exclusions or Reductions", a list of all qualifications, exclusions or reductions affecting the issuance of the policy, the payment of the policy premium or the recovery of the policy benefits.

20. Filing Requirements:

- (a) The Superintendent of the common law Province in which the company's head office is located (or where the head office in Canada is not in one of the common law Provinces, then Ontario) will act as the clearing-house for comments or suggestions of the other common law Superintendents.
- (b) The advertisement is to be filed in all common law Provinces simultaneously and the Superintendents therein will advise the clearing-house Province if they think the advertisement departs from the Guideline or if a Superintendent wishes to deal directly with the insurer on the substance of the advertisement.
- (c) If, within two weeks of the receipt of the advertisement, a Superintendent has not registered an objection to it, the clearing-house Province will assume none exists.
- (d) The Superintendent of the clearing-house Province will advise the company of any objections that have been registered and also give the company his own comments.
- (e) If there are objections, the company should resolve them directly with the Superintendent of the clearing-house Province.

**B. GUIDELINES GOVERNING GROUP ACCIDENT
INSURANCE AND GROUP SICKNESS INSURANCE
EFFECTIVE JANUARY 1, 1976**

1. In these rules:

- (a) "Blanket insurance" means that class of group insurance which covers loss arising from specific hazards incident to or defined by reference to a particular activity or activities;
- (b) "creditors group insurance" means insurance effected by a creditor in respect of the lives or well-being of his debtors whereby the lives or well-being of the debtors are insured severally under a single contract;
- (c) "group insurance" includes creditors group insurance and savings group insurance;
- (d) "insurance" means accident insurance and sickness insurance;
- (e) "member" includes employee;

- (f) “savings group insurance” means insurance effected by a bank, credit union, trust company, investment contract company, mutual fund company or a like corporation whereby the lives or well-being or the life and well-being of depositors or investors are insured severally under a single contract in amounts related to the amounts deposited or invested with the policyholder or to the amount to be deposited or invested with the policyholder to complete a savings or investment plan.
2. Section 3 does not apply to blanket insurance, creditors group insurance or savings group insurance.
3. A contract of group insurance shall be issued only where the group is:
- (a) a group of employees of the same employer or a number of associated employers
 - (b) a professional or occupational group
 - (c) a trade union
 - (d) a credit union
 - (e) a group of students
 - (f) an organization of persons which:
 - (i) is formed for a specific purpose other than the purchase of insurance;
 - (ii) requires its members to pay a membership fee at least once annually;
 - (iii) has had a reasonably stable membership over the previous three years; and
 - (iv) holds regular meetings of members at which its officers are elected;
 and provision is made for adequate administrative facilities and for collecting and remitting premiums.
4. (1) A contract of group insurance shall not be issued unless the benefits are payable according to a schedule that is non-discriminatory as between
- (a) members; or
 - (b) members of the same class.
- (2) The schedule in subsection (1)
- (a) may designate the broad classes of members;
 - (b) may relate the benefits payable to earnings, age, dependants or years of service or a combination of such factors.
- (3) This section does not apply to creditors group insurance or savings group insurance.
5. (1) In the case of a contract of creditors group insurance or of savings group insurance there shall be disclosed on the application or other

form used by the applicant to obtain the insurance the specific charge, if any, to be levied against him to pay the whole or part of the cost of his insurance.

- (2) Where the eligibility for insurance under a contract of creditors group insurance or savings group insurance, or the insurance coverage thereunder, is conditioned on health or subject to conditions or limitations related thereto, the application for the insurance;
 - (a) shall contain specific questions concerning health; and
 - (b) shall contain specific statements setting forth the conditions or limitations related to health to which the insurance coverage is subject;and
 - (c) questions difficult to answer without qualification; or
 - (d) statements requiring qualification;are to be avoided.
 - (3) In the case of a contract for creditors group insurance or savings group insurance where:
 - (a) a specific charge is levied against the applicant; or
 - (b) the eligibility for insurance is conditioned on health; or
 - (c) the insurance coverage is subject to conditions or limitations;a copy of the completed application or other form signed by the applicant shall be delivered to him at the time of signing.
6. A contract of Creditors Group Insurance shall not provide a periodic disability income benefit that is payable to a group person insured for any amount that exceeds the periodic payment due to the creditor or his assignee.
7. No insurer shall directly or indirectly pay or allow to the policyholder or to any agent or employee thereof under a group contract:
- (a) compensation for the solicitation or negotiation of insurance on any person insured under the contract; or
 - (b) reimbursement of expenses for the collection of premiums in excess of five percent of the premiums collected from the persons insured.
8. Number 8 is struck out.
9. (1) Except as hereinafter provided, Sections 1 to 6 do not apply to contracts in effect on the thirty-first day of December 1975, or to any renewal of those contracts, and Section 7 applies to and in respect of all contracts of group insurance and renewals thereof, regardless of date of issue.
- (2) For the purpose of this Section, a contract issued as a renewal of another contract, that immediately before the renewal was out of force and had been out of force for three months or more, shall be deemed to be a new contract.

- (3) For the purpose of this Section, a contract issued as a renewal of another contract and providing a plan of benefits that:
 - (a) exceeds in a material amount the plan of benefits provided under that other contract; or
 - (b) includes benefits that are not included in the plan of benefits provided under that other contract;shall be deemed to be a new contract.
 - (4) Where a contract in effect on the thirty-first day of December, 1975, or any renewal thereof complies with a provision of these rules, that provision applies to that contract and any renewal thereof.
 - (5) Section 5 shall, in the case of creditors group insurance and savings group insurance issued to credit unions, come into effect on the first day of January 1977.
10. (1) In this Rule, "government sponsored plan or support program cost-of-living adjustment" means an increase in the level of benefits under any government sponsored plan or support program to reflect an increase in the cost-of-living, as measured by the appropriate governmental agency, but does not include any change in the level of benefits that results from a change in the formula used to calculate the initial benefit level under any such plan.
- (2) The benefit payable to an insured under a contract of group insurance with respect to loss of income because of disability shall not be reduced because of a government sponsored plan or support program cost-of-living adjustment occurring after the date on which benefits become payable under the insurance contract.
 - (3) Notwithstanding subsection (2), if a contract of group insurance provides for cost-of-living adjustments in the level of benefits payable with respect to loss of income because of disability, then such benefits may be reduced by the lesser of
 - (a) Government sponsored plan or support program cost-of-living adjustments occurring after the date on which benefits become payable under the insurance contract, and
 - (b) The proportion of such adjustments that the percentage rate of cost-of-living adjustments made under the insurance contract during the same period is of the percentage rate of increase in government sponsored plan or support program cost-of-living adjustments.
 - (4) This Rule shall have effect from January 1, 1978 except:
 - (a) in the case of a contract of group insurance which is subject to a collective bargaining agreement, in which case the provisions of Rule 10 shall have effect from the expiration of the collective bargaining agreement next following January 1, 1978, but in no event later than January 1, 1981, or

- (b) in the case of a contract of group insurance, other than those referred to in (4)(a), which has not been subject to renewal until a date subsequent to January 1, 1978, in which case the provisions of Rule 10 shall have effect from the date of renewal of the contract next following January 1, 1978, or
- (c) in the case of claims established prior to the renewals covered in 10(4)(a) and 10(4)(b) in which case the Rule shall have effect from January 1, 1981.

C. GUIDELINES FOR DISCLOSURE RELATIVE TO ACCIDENT INSURANCE AND SICKNESS INSURANCE EFFECTIVE JULY 1, 1976

1. In these guidelines:
 - (a) "insurance" means accident insurance or sickness insurance or accident and sickness insurance issued in Canada;
 - (b) "information statement" means an information statement in the form set out in Section 3 of these guidelines.
2. These guidelines, except where stated to the contrary, apply to all individual policies of accident insurance, sickness insurance, or accident and sickness insurance, as those terms are defined in The Insurance Act, with the following exceptions:
 - (a) non-renewable insurance issued for a period of six months or less than is issued in relation to a ticket of travel; or
 - (b) non-renewable policies issued for a term of six months or less which cover loss arising from specific hazards incident to or defined by reference to a particular activity; or
 - (c) individual policies of accident insurance, sickness insurance, or accident and sickness insurance which are issued as conversions from a group insurance contract, if the individual policy provides benefits identical to those provided to the group person insured under the group contract.
3. An information statement in the following form with appropriate percentage inserted shall be placed in:
 - (a) each application for a policy of insurance; and
 - (b) every advertisement and piece of sales literature that illustrates the cost of insurance for a specific type of policy.

Information Statement

For policies of this type, the insurer anticipates that % of the premiums will be required for claims.

This is not a contractual obligation.

4. (a) In an application for insurance the information statement shall be placed immediately before the place for the signature of the applicant and shall be printed in type not smaller than 9 point type.
- (b) In an advertisement or in sales literature the information statement shall be placed on the first page on which reference to the cost of insurance appears and shall be printed in a type of the same size and character as the type used to describe the benefits to the insured under the policy.
5. The percentage to be inserted in an information statement relating to a type of insurance policy shall be estimated by the actuary for the insurer on the basis of the assumption of morbidity, mortality, lapse and interest that the insurer used in establishing the premiums to be charged for the policy.
6. Each insurer issuing policies of insurance in Canada shall on or before June 30 in the year 1977, and on or before June 30 in each succeeding year, provide to the Superintendents of Insurance of the Provinces of Canada,
 - (a) a certificate of an officer of the insurer certifying that all applications of policies of insurance received by the insurer during the calendar year preceding the date of filing, and all advertisements and sales literature published or released by the insurer during the calendar year preceding the date of filing which illustrated the cost of insurance for a specific type of policy contained an information statement as required under these guidelines; and
 - (b) a certificate of an actuary either certifying that the claims experience up to the end of the calendar year preceding the date of filing under each type of policy of insurance issued by the insurer is not significantly inconsistent with that anticipated by the information statement contained in or relating to each such type of policy of insurance, or indicating each type of policy of insurance issued by the insurer for which the claims experience up to the end of the calendar year preceding the date of the filing is significantly inconsistent with that anticipated by the information statement contained in or relating to that type of policy of insurance.
7. Where an actuary indicates that the claims experience of a type of policy of insurance is significantly lower than that anticipated by that information statement relating to that type of policy of insurance he shall indicate what, in his opinion, caused the variation and what corrective action, if any, the insurer intends to take to rectify the variation.
8. For the purpose of giving a certificate under clause (b) of Section 6 the actuary shall calculate and consider the claims experience ratio of each type of policy for the whole period from the coming into effect of these guidelines and for the three most recent calendar years if such period is less than the whole period from the coming into effect of these guidelines.

9. In determining the claims experience ratio referred to in Section 8, an actuary shall use the following formula:

Formula

$$\text{Claims Experience Ratio} = \frac{C + R - S \times 100}{P - U + v}$$

In this formula—

- C is the accumulation with interest of claims paid under the type of policy during the period for which the claims experience is being calculated;
- R is the total of current reserves, including policy and claims reserves, held for the type of policy as at the end of the period for which the claims experience is being calculated;
- S is the total of reserves, including policy and claims reserves, held for the type of policy at the beginning of the period for which the claims experience is being calculated, accumulated with interest to the end of the period;
- P is the accumulation with interest of premiums paid under the type of policy during the period for which the claims experience is being calculated;
- U is the unearned premium reserve held for the type of policy as of the end of the period for which the claims experience is being calculated; and
- v is the unearned premium reserve held for the type of policy at the beginning of the period for which the claims experience is being calculated accumulated with interest to the end of the period.

For the purpose of this Section, interest should be at the rate of 5% p.a.

These guidelines come into effect as of July 1, 1976.

D. GUIDELINES FOR THE DISCLOSURE OF BENEFITS, LIMITATIONS AND EXCLUSIONS IN INDIVIDUAL POLICIES OF ACCIDENT AND SICKNESS INSURANCE EFFECTIVE JANUARY 1, 1978

1. The purpose of these guidelines is to encourage the issuance of clear and readable policies of accident insurance, sickness insurance or accident and sickness insurance to the end that purchasers may understand, as fully as possible, the coverage which is provided.
2. These guidelines, except where stated to the contrary, apply to all individual policies of accident insurance, sickness insurance, or accident and sickness insurance, as those terms are defined in The Insurance Act, with the following exceptions:

- (a) non-renewable insurance issued for a period of six months or less that is issued in relation to a ticket of travel; or
 - (b) non-renewable policies issued for a term of six months or less which cover loss arising from specific hazards incident to or defined by reference to a particular activity; or
 - (c) individual policies of accident insurance, sickness insurance, or accident and sickness insurance which are issued as conversions from a group insurance contract, if the individual policy provides benefits identical to those provided to the group person insured under the group contract.
3. A statement disclosing the principal benefits, conditions, exclusions or limitations of the policy shall be prepared and delivered to the insured at the time of delivery of the policy. The statement shall have as a caption the words “INFORMATION ON YOUR INSURANCE POLICY #_____. READ CAREFULLY” and shall contain the following information:
- (a) A statement that the policy covers losses arising from all accidents, all sicknesses, or from both, or only losses arising from specific accidents or specific sicknesses.
 - (b) A statement of whether a lump sum or sums, or periodic payments are provided and the applicable deductible amount or waiting period.
 - (c) All definitions of total and partial disability in the policy should be reproduced.
 - (d) A statement of the circumstances which may result in a reduction in the benefits payable under the policy.
 - (e) If the policy is not guaranteed renewable and non-cancellable, to age 65, as those terms are defined in the Code of Ethics of The Canadian Association of Accident and Sickness Insurers as recorded in the proceedings of the late 1972 Annual Meeting of Superintendents of Insurance, then the conditions under which the insurer may raise the premium, reduce benefits payable, refuse to renew or cancel the policy shall be stated.
 - (f) If benefits provided are dependent on the policy remaining in force, the requirements for payment of premiums in this case, and any grace period or waiver of premium during disability benefit, if included in the policy, shall be stated.
 - (g) If coverage for direct payment by the insurers of the insured's expenses is not provided until the insured actually pays the expenses, then this fact should be stated.
 - (h) If coverage is not provided 24 hours a day during the term of the policy, then the restricted coverage provided should be stated.

- (i) Unless acknowledged by a signed amendment form, any exclusions, conditions or limitation which are imposed after the application was signed shall be disclosed in a statement to the following effect:

“The following exclusions, conditions or limitations on benefits provided by this policy have been imposed as a result of information supplied by you on the application or other evidence of insurability received by the insurance company:

”

- (j) If any pre-existing conditions, whether or not disclosed to the company, are not covered, then this fact shall be stated.
- (k) The information statement required by the Guidelines Relating to Disclosure of Anticipated Loss Ratios on Individual Policies of Accident and Sickness Insurance shall be included.

4. The disclosure statement shall also contain the following notices:

“These statements are a brief summary of some of the important provisions of your policy; however, they are not part of the policy and are not terms of the insurance contract. PLEASE REFER TO YOUR POLICY FOR DETAILED PROVISIONS.”

“You have the right to cancel the policy and receive a full refund of premiums by notifying the company in writing at the following address provided the notification is postmarked not later than 10 days after the date of delivery to you of this information; provided that in the event of cancellation of a reinstated policy, the refund or premiums shall be only the amount of premiums tendered to effect the reinstatement.”

(INSURER’S ADDRESS)

- 5. The requirements of these Guidelines apply to a reinstatement of the policy if any of the policy terms are being changed.
- 6. Except as required in Guideline 3(c) above, the information in the disclosure statement shall be stated in concise, colloquial language that is clear, unambiguous and easily readable.
- 7. These guidelines come into effect as of January 1, 1978.

**E. PROPOSED GUIDELINE FOR DISCLOSURE
ON GROUP AND CREDITORS GROUP
ACCIDENT AND SICKNESS INSURANCE**

- 1. This guideline applies to group insurance contracts and creditors group insurance contracts providing accident and/or sickness benefits, except blanket insurance, a contract of group insurance of a non-renewable type issued for a term of six months or less or a credit card group insurance contract.

2. In the case of a contract of group insurance, an insurer shall issue for delivery by the insured to each group person insured a certificate or other document in which are set forth the following particulars:
 - (a) The name of the insurer and sufficient identification of the contract.
 - (b) The amount or the method of determining the amount of insurance on the group person insured and on any person insured.
 - (c) The circumstances under which the insurance terminates, and the rights, if any, upon such termination of the group person insured and of any person insured.
 - (d) On the face page, or in an otherwise suitably prominent position, words to the effect that the insurance information therein is important and suggesting that the certificate or other document be kept in a safe place.
 - (e) The name of the insured.
 - (f) The procedure to be followed in making a claim including:
 - (i) to whom and where claims should be made;
 - (ii) the time limit within which a claim must be made or within which a notice or proof of claim must be submitted,
 - (iii) particulars about the form of claim; for example, if it has to be in writing, this should be stated.
 - (g) The principal benefits, conditions including eligibility, exclusions or limitations shall be listed together with a notice to the effect that the statements are a summary of some of the provisions of the master policy; however, they are not part of the master policy and are not terms of the insurance contract.
 - (h) Where and from whom more detailed information about the benefit or other provisions relevant to the group person insured may be obtained or copies of those provisions may be purchased.
3. (a) In the event of material change, or termination of the contract without replacement by another group insurance contract or private health service plan, the insurer shall issue for delivery by the insured to the group person insured, notification of such material change or termination.
- (b) If the insurer fails to provide the group person insured with the notification required in clause (a), the group person insured shall continue to be entitled to benefits for the period for which premiums have been paid in full and shall be entitled to exercise any conversion privilege during the 60 days after such period. These entitlements shall accrue to the group person insured unless he should have been aware of the material change or termination by reason of information provided to him in the certificate or other document.

- (c) An insurer shall not be liable to pay benefits under 3(b) for claims that first begin more than six years after the material change or termination of the contract.

4. This guideline shall have effect from January 1, 1982.

F. PROPOSED GUIDELINE GOVERNING CREDIT CARD GROUP ACCIDENT AND SICKNESS INSURANCE

1. This guideline applies to group insurance contracts providing accident and/or sickness benefits to the named holders of a credit card from a specific credit card issuer.
2. This guideline does not apply to group insurance contracts providing benefits for loss of income because of disability due to sickness.
3. The insurer issuing a credit card group insurance policy shall accept the responsibility for all printed material regarding the insurance provided to each group person insured.
4. An insurer issuing or materially amending a credit card group insurance contract, shall issue and deliver to each group person insured a certificate or other document in which are set forth the following particulars:
 - (a) The name of the insurer and sufficient identification of the contract.
 - (b) The amount or the method of determining the amount of insurance on the group person insured and on any person insured.
 - (c) The circumstances under which the insurance terminates, and the rights upon such termination of the group person insured and of any person insured.
 - (d) On the face page, or in an otherwise suitably prominent position, words to the effect that the insurance information therein is important and suggesting that the certificate or other document be kept in a safe place.
 - (e) The name of the insured.
 - (f) The procedure to be followed in making a claim including:
 - (i) to whom and where claims should be made;
 - (ii) the time limit within which a claim must be made or within which a notice or proof of claim must be submitted; and
 - (iii) particulars about the form of claim; for example if it has to be in writing, this should be stated.
 - (g) The principal benefits, conditions including eligibility, exclusions or limitations shall be listed together with a notice to the effect that the statements are a summary of some of the provisions of the master policy; however, they are not part of the master policy and are not terms of the insurance contract.

- (h) Where and from whom more detailed information about the benefit or other provisions relevant to the group person insured may be obtained or copies of those provisions may be obtained.
5. The contract between the insurer and the credit card organization shall provide that:
 - (a) Where insurance premiums are charged to the credit card they will be given priority over other amounts-due, including accrued interest, when applying payments by a credit card holder;
 - (b) In the event of non-payment for any reason (including non-payment of account, revocation of card privilege or termination of plan) the insurer will grant 60 days of grace during which the insurance remains in force;
 - (c) The insurer shall notify each group person insured at least 30 days prior to expiration of the grace period and shall advise the group person insured of his conversion privilege;
 - (d) In the event of termination for any reason each group person insured will have the right to convert to an individual plan providing similar benefits if application is made within the 60 days of grace;
 - (e) The converted plan shall be issued at a premium which does not exceed the standard rate for currently issued individual policies for that insurer.
 6. The insurer or credit card issuer must provide each group person insured with an address and telephone number within Canada where the group person insured can obtain information including coverage and claims procedures from properly qualified and knowledgeable personnel.
 7. The anticipated loss ratio must be disclosed in accordance with the Guideline for Disclosure Relative to Accident and Sickness Insurance.
 8. All solicitation of Credit Card Group Insurance in the form of advertisements, brochures and related literature must observe the Guidelines respecting Mass Advertising of Life, Accident and Sickness Insurance.
 9. This guideline shall have effect from July 1, 1981.

APPENDIX H

(referred to in Chapter 22)

PORTIONS OF SCHEDULE E OF THE INSURANCE ACT REGARDING MANDATORY MEDICAL REHABILITATION AND ACCIDENT BENEFITS IN MOTOR VEHICLE LIABILITY POLICIES

Accident Benefits Section

The Insurer agrees to pay to or with respect to each insured person as defined in this section who sustains bodily injury or death by an accident arising out of the use or operation of an automobile.

Subsection 1—Medical, Rehabilitation and Funeral Expenses

1. All reasonable expenses incurred within four years from the date of the accident as a result of such injury for necessary medical, surgical, dental, chiropractic, hospital, professional nursing and ambulance service and for any other service within the meaning of insured services under The Health Insurance Act and for such other services and supplies which are, in the opinion of the physician of the insured person's choice and that of the Insurer's medical advisor, essential for the treatment, occupational retraining, or rehabilitation of said person, to the limit of \$25,000 per person.
2. Funeral expenses incurred up to the amount of \$1,000 in respect of the death of any one person.

The Insurer shall not be liable under this Subsection for those portions of such expenses payable or recoverable under any medical, surgical, dental, or hospitalization plan or law or, except for similar insurance provided under another automobile insurance contract, under any other insurance contract or certificate issued to or for the benefit of, any insured person.

Subsection 2—Death Benefits and Loss of Income Payments

Part I—Death Benefits

- A. Subject to the provisions of this Part, for death that ensues within 180 days of the accident or within 104 weeks of the accident if there has been continuous disability during that period, a payment—based on the status at the date of the accident of the deceased in a household where a spouse or dependants survive—of the following amounts:

Head of Household	\$10,000
Spouse of the Head of the Household	10,000
Dependant within the meaning of sub-subparagraph b of subparagraph 3 of paragraph B	2,000

In addition, with respect to death of the head of the household, where there are two or more survivors—spouse or dependants—the principal sum payable is increased \$1,000 for each survivor other than the first.

Part II—Loss of Income

Subject to the provisions of this Part, a weekly payment for the loss of income from employment for the period during which the insured person suffers substantial inability to perform the essential duties of his occupation or employment, provided,

- (a) such person was employed at the date of the accident;
- (b) within 30 days from the date of the accident the insured person suffers substantial inability to perform the essential duties of his occupation or employment;
- (c) no payments shall be made for any period in excess of 104 weeks except that if, at the end of the 104 week period, it has been established that such injury continuously prevents such person from engaging in any occupation or employment for which he is reasonably suited by education, training or experience, the Insurer agrees to make such weekly payments for the duration of such inability to perform the essential duties.

Amount of the Weekly Payment—The amount of a weekly payment shall be the lesser of,

- (a) \$140 per week; or
- (b) 80 per cent of the insured person's gross weekly income from employment, less any payments for loss of income from employment received by or available to such person under,
 - (i) the laws of any jurisdiction,
 - (ii) wage or salary continuation plans available to the person by reason of his employment, and
 - (iii) Part III of this Subsection 2.

but no deduction shall be made for any increase in such payment due to a cost of living adjustment subsequent to the insured person's substantial inability to perform the essential duties of his occupation or employment or for the first two weeks of such substantial inability.

For the purpose of this Part,

- (1) there shall be deducted from an insured person's gross weekly income any payments received by or available to him from part-time or other employment or occupation subsequent to the date of the accident;
- (2) a principal unpaid housekeeper residing in the household not otherwise engaged in occupation or employment for wages or profit, if injured, shall be deemed disabled only if completely incapacitated and unable to perform any of his or her household duties and, while so incapacitated, shall receive a benefit at the rate of \$70 per week for not more than 12 weeks;
- (3) a person shall be deemed to be employed,
 - (a) if actively engaged in an occupation or employment for wages or profit at the date of the accident; or
 - (b) if 18 years of age or over and under the age of 65 years, so engaged for any six months out of the preceding 12 months;
- (4) a person receiving a weekly payment who, within 30 days of resuming his occupation or employment is unable to continue such occupation or employment as a result of such injury, is not precluded from receiving further weekly payments;
- (5) except for the first two weeks of disability where the payments for loss of income payable hereunder, together with payments for loss of income under another contract of insurance other than a contract of insurance relating to any wage or salary continuation plan available to an insured person by reason of his employment, exceed the actual loss of income of the insured person, the insurer is liable only for that proportion of the payments for loss of income stated in this policy that the actual loss of income of the person insured bears to the aggregate of the payments for loss of income payable under all such contracts.

APPENDIX I

(referred to in Chapter 28)

**RECOMMENDATIONS
OF THE HONOURABLE MR. JUSTICE HORACE KREVER
REGARDING EMPLOYEE HEALTH INFORMATION
AS CONTAINED IN
“CHAPTER 30—EMPLOYEE HEALTH INFORMATION—
REPORT OF THE COMMISSION OF INQUIRY INTO THE
CONFIDENTIALITY OF HEALTH INFORMATION”
PRESENTED TO THE MINISTER OF HEALTH
SEPTEMBER 30, 1980**

107. That legislation be enacted to make it an offence for an employer to reveal any health information concerning any present or former employee to a third party (unless otherwise required by law) without the consent of the employee.
108. That all health information be stored separately from other employee information.
109. That all persons handling employee health information be given written guidelines relating to the confidentiality of the information. These guidelines, which should be established by the Ministry of Labour in consultation with the Ministry of Health, should deal with the collection, retention, storage, security, access, disclosure and destruction of identifiable employee health information held by employers.
110. That all health information be kept in cabinets which should be locked and accessible only to those persons directly involved in administering that information.
111. That for an internal transfer of information within the employer, from one department or one section to another, the consent of the employee be obtained.
112. That an employee have a right of access to all of his or her health information held by an employer, including a right to request that correction be made, if necessary, or a notation of his or her objection.
113. That the results of laboratory testing performed on employees or applicants for employment be sent either to the health personnel (if any) or to the physician requesting the tests. Non-health personnel should not be permitted to open the reports of the test results.
114. That the sending of employee health information outside the Province of Ontario be prohibited unless all identifying information is removed.

115. That where the reason for storing the information outside Ontario is that it be used for epidemiological research in respect of the employer's operations, a code be devised to enable an employee to be identified, but the key to the code must be retained in Ontario.
116. That legislation be enacted to make it clear that a professional employee's duty of confidentiality transcends his or her duty to obey an employer's instructions, where those instructions require the employee to reveal information held in confidence.
117. That the responsibility for the storage and control of health information about employees be declared to be that of the health professionals employed by the employer, or, if there are none employed, a physician designated by the employer.
118. That the employer not be allowed access to health information about an employee without the consent of the employee concerned.
119. That where, in the opinion of a health professional, disclosure of confidential information is necessary because of a clear danger to the employee, fellow employees, or to the product resulting in a danger to the public and
 - (a) the employee concerned consistently refuses to give consent, and
 - (b) a second opinion is obtained from the employee's personal physician when the concern is for the health of the employee, or from the medical officer of health when the risk is to the public or to fellow employees,the health professional may make the disclosure to the proper person at management level after giving notice in writing to the employee, which notice shall indicate the confidential information intended to be disclosed.
120. That the only information which can be given to a prospective employer after a pre-employment medical examination be whether the applicant is fit for the employment.
121. That if an applicant is fit with certain limitations, these limitations must be stated without disclosing the reasons for the limitations, for example, "unable to lift heavy loads or loads above X pounds" or "limited bending".
122. That where a medical department staffed by health personnel is maintained by the employer, the results of the examination be kept in the medical department but not be available to the employer except as recommended in the two preceding recommendations.
123. That where the pre-employment examination is done by a physician not employed by the employer, the employer provide that physician with a job description so that he or she may be aware of the fitness requirements

of the position and that a copy of the recommendation be given to the applicant.

124. That the applicant be entitled to a copy of the examining physician's record of examination if he or she so requests.
125. That where the recommendation is that an applicant is not fit for the position an explanation for the recommendation, indicating the reasons, be given to the applicant by the physician making the examination, if so requested.
126. That whenever an employee is required to undergo a periodic medical examination or a medical examination because of a suspected health problem, and as a result an opinion is given that the employee's job should be changed, recommendations 120 to 125 apply.
127. That the Ministry of Labour in consultation with the Ministry of Health prepare a form that will be sufficient to:
 - (a) justify an employee's absence; and
 - (b) certify an employee's fitness to return to work.
128. That the medical department be responsible for accepting medical certificates for short term sickness and advising those responsible for the payment whether or not payment should be made for the period of absence. The certificates should be retained and filed in the medical department.
129. That where there is no medical department,
 - (a) depending on the size and organization of the employer, a senior person in each department, branch or unit be given the authority referred to in the preceding recommendation; and
 - (b) no copies be made of the certificates, which should be kept in a locked cabinet.
130.
 - (1) That where an employee makes a claim on a sickness and accident insurance or other insurance policy provided by the employer the claim form be sent directly to the insurance company and not to the employer.
 - (2) That the employer be prohibited from requesting a copy of the claim form containing the diagnosis from either the claimant or the insurance company.
 - (3) That a separate form be prepared for employment information necessary to complete the claim.
131. That where the employer is a self-insurer or acts as an agent for an insurance company for sickness and accident benefits, documents containing employees' health information be maintained separately from other records maintained by the employer.

- (2) That the information in these documents not be made available for use in making employment decisions.
 - (3) That access not be allowed to any other employee of the employer, including health personnel, without the consent of the individual concerned.
- 132. That the authorization for release of medical information on a claim form be so phrased as to make it clear that the only information required relates to the disability for which the claim is made.
 - 133. That information relating to health and accident claims of employees provided by an insurance company to an employer consist of statistical information only without identifying employees, except when given to the medical department of the employer.
 - 134. That where information which identifies employees is given to the medical department, it shall not be available for use in making employment decisions.
 - 135. That where the employer maintains a medical department, all requests from the Workmen's Compensation Board for information relating to previous similar disabilities be directed to the medical department.
 - 136. That where medical information is forwarded to the Workmen's Compensation Board, a copy be given to the claimant.
 - 137. That where no medical department is maintained by the employer, no information relating to previous similar disabilities be forwarded to the Workmen's Compensation Board without the authorization of the claimant.
 - 138. That where an employer has a medical department, those persons responsible for administering workmen's compensation claims on behalf of the employees be made part of the medical department. The persons who become part of the medical department, with the implementation of this recommendation, should be denied access to other records generated by the medical department.
 - 139. That where there is no medical department, the persons responsible for processing the claims on behalf of the employer ensure that the claims are kept separate from other records on the claimant and are not accessible to other personnel.
 - 140. That where a claim is transferred from workmen's compensation to a claim under sickness and accident benefits or short term illness benefits the claimant be advised and his or her consent be obtained before his or her health information is transferred.
 - 141. That *The Health Insurance Act, 1972* be amended to make it possible for any authorized representative of a person personally entitled to information from OHIP to receive any information that person may receive.



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